SUPPLEMENT
The Association

THE SIXTY-EIGHTH ANNUAL MEETING OF THE CANADIAN MEDICAL ASSOCIATION, HELD IN OTTAWA, ONTARIO

June 21, 22, 23, 24, 25, 1937

DURING the week of June 21, 1937, one of the most outstanding meetings of the Canadian Medical Association was held in Ottawa, the capital city of Canada, when 1,122 Doctors, 574 Ladies and 305 Young People (sons and daughters of visiting doctors), making a total of 2,001, congregated at the Chateau Laurier for a week that will not soon be forgotten.

An excellent scientific program was presented. A new undertaking on the part of the Association was the department of Scientific Exhibits, and so many favourable comments were heard on all sides that one would infer that, for the future, this new feature has come to stay.

For the Ladies and Young People, the week was marked by a continuous round of entertainment, and our Ottawa hosts and hostesses left nothing undone that would add to the comfort or enjoyment of their guests during the week. At all times, there was evident that personal interest which means so much to the stranger attending a convention.

THE ANNUAL GENERAL MEETING OF THE ASSOCIATION

On Wednesday evening, June 23rd, the Annual General Meeting of the Association was held. This was attended by His Excellency the Right Honourable Baron Tweedsmuir of Elsfield, G.C.M.G., C.H., Governor-General of Canada. At this function, Honorary Membership in the Association was conferred upon the three overseas speakers: Sir Harold Beckwith Whitehouse, Birmingham, Eng., Mr. Watson Jones, Liverpool, Eng., and Dr. Antoine Lacassagne, Paris. An announcement was made of the election of the following to Senior Membership: Dr. R. E. McKechnie, Vancouver, B.C., Dr. S. E. Fleming, Sault Ste. Marie, Ont., Dr. J. K. McLeod, Sydney, N.S.

After his installation as President of the Association, Dr. T. H. Leggett gave his inaugural address.

Following the ceremony, all retired to the Drawing Room where His Excellency along with the President and Mrs. Leggett received. The remainder of the evening was spent in dancing followed by refreshments.

The annual golf tournament was held on Friday afternoon, June 25th, the winners being as follows: The Ontario Cup, Dr. A. D. MacCallum, Toronto; The Hamilton Medical Society Trophy, Dr. A. V. Kniewasser, Ottawa; London Academy of Medicine Trophy, won by the Acadamy of Medicine, Toronto, the players being Drs. Fulton Risdon, R. E. Davidson, G. C. Cameron, W. C. Givens.

MEETING OF THE GENERAL COUNCIL

The General Council met on Monday and Tuesday, June 21st and 22nd, with 73 delegates present from all parts of Canada. Dr. Geo. S. Young, the Chairman, welcomed the members.

The following is a list of those who registered:

Harvey Agnew, Toronto; A. W. Bagnall, Vancouver; D. M. Baltzan, Saskatoon; A. T. Bazin, Montreal; James E. Bloomer, Moose Jaw; E. W. Boak, Victoria; W. Gordon Byers, Montreal; G. Stewart Cameron, Peterborough; Malcolm H. V. Cameron, Toronto; F. J. H. Campbell, London; W. K. Colbeck, Welland; J. R. Corston, Halifax; D. E. H. Cleveland, Vancouver; W. H. Delaney, Quebec; Léon Gérin-Lajoie, Montreal; W. E. Gray, Milltown; R. W. L. Earle, Perth; J. H. Geddes, London; A. L. Gerow, Fredericton; A. T. Gillespie, Fort William; W. F. Gillespie, Edmonton; J. C. Gillie, Fort William; Duncan Graham, Toronto; Judson V. Graham, Halifax; H. G. Grant, Halifax; J. A. Gunn, Winnipeg; Robt. I. Harris, Toronto; C. E. Hill, Lansing; T. Edward Holland, Winnipeg; Alan B. Jackson, Simcoe; F. W. Jackson, Winnipeg; George R. Johnson, Calgary; R. K. Johnston, Eston; W. A. Jones, Kingston; A. D. Kelly, Toronto; A. Stanley Kirkland, Saint John; N. B. Kyles, Orangeville; T. H. Leggett, Ottawa; J. G. K. Lindsay, Saskatoon; H. H. Milburn, Vancouver; E. S. Moorhead, Winnipeg; W. L. Muir, Halifax; D. Murray, Tatamagouche; H. E. MacDermot, Montreal; N. E. MacDougall, Vancouver; J. S. McEachern, Calgary; F. D. McKenty, Winnipeg; A. J. MacKenzie, Toronto; K. A. MacKenzie, Halifax; A. L. McLean, Halifax; D. S. Macnab, Calgary; W. J. McNally, Montreal; J. D. McQueen, Winnipeg; A. G. Nicholls, Montreal; F. S. Patch, Montreal; R. K. Paterson, Ottawa; W. S. Peters, Brandon; Egerton L. Pope, Edmonton; A. Primrose, Toronto; George A. Ramsay, London; Hermann M. Robertson, Victoria; O. E. Rothwell, Regina; Fred W. Routley, Toronto; T. C. Routley, Toronto; H. W. Scott, Bienfait; H. B. Small, Ottawa; Howard Spohn, Vancouver; G. F. Strong, Vancouver; P. H. T. Thorlakson, Winnipeg; H. M. Torrington, Sudbury; Wallace Wilson, Vancouver; A. B. Whytock, Niagara Falls; H. M. Yelland, Peterborough; and George S. Young, Toronto.

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Messages of regret at inability to be present were read from the following: C. F. Wylde, Montreal; Bernard Mooney, Edmonton; H. H. Murphy, Kamloops; Jas. Stevenson, Quebec; W. J. Knox, Kelowna, B.C.; J. J. Ower, Edmonton; A. R. Munroe, Edmonton; Albert LeSage, Montreal.

Messages of greeting were received from the following: Ontario Retail Druggists Association; Canadian Pharmaceutical Association; Nurses Alumnæ Association of the Ottawa General Hospital; Canadian Council for Crippled Children.

REPORT OF THE COMMITTEE ON ARCHIVES

Mr. Chairman and Members of the General Council:—

Your Committee on Personal Archives reports with regret the loss of the following members, by death, during the past year:—

Allen, Harold McClellan, Toronto, Ont.
Alway, William Robert, Waterford, Ont.
Atkinson, Wilfred Lorne, Selkirk, Man.
Black, Vaughan Elderkin, Moose Jaw, Sask.
Buckley, George Edward, Guysboro, N.S.
Burroughs, Charles McIntosh, Sudbury, Ont.
Campbell, Duncan Alexander, Bridgewater, N.S.
Campbell, Robert James, Winnipeg, Man.
Challener, Reginald Eugene Sproston, Toronto, Ont.
Chapman, Lorenzo, Grand Falls, N.B.
Chipman, William Wallace, Vancouver, B.C.
Corbet, George G., Saint John, N.B.
Craig, James Eldon, Ottawa, Ont.
Drew, George (Life Member), New Westminster, B.C.
Forin, Alexander, Edmonton, Alta.
Forbes, Albert Ernest, Moncton, N.B.
Gariepy, Ernest, Montreal, Que.
Klotz, Oskar, Toronto, Ont.
Lynn, Robert Wesley, Lethbridge, Alta.
Marlow, Frederick William, Toronto, Ont.
Mason, John James, Vancouver, B.C.
Montgomery, Wilson, Embro, Ont.
McConnell, John Herbert, Toronto, Ont.
McCoy, Samuel Harvey, Ottawa, Ont.
Macdonald, William Alexander Chisholm, Windsor, Ont.
Ness, William, Westmount, Que.
Nunn, Herbert John, Dawson, Yukon
Olmsted, Ingersoll, Hamilton, Ont.
Phinney, Willoughby Schafner, Yarmouth, N.S.
Reddy, Herbert Lionel, Montreal, Que.
Salmon, Morley Cuthbert, Victoria, B.C.
Scrimger, Francis Alexander Caron, Montreal, Que.
Secord, Edward Reginald, Brantford, Ont.
Smith, Arthur Dalton, Mitchell, Ont.
Smith, Israel Goldwin, Ottawa, Ont.
Sponagle, John Addy, Middleton, N.S.
Stefansson, Jon, Winnipeg, Man.
Stewart, David Alexander, Ninette, Man.
Tetrault, Arthur, Tetrault, Que.
Thornton, Robert Stirton, Vancouver, B.C.
Warner, Alvin McPhee, Vancouver, B.C.

During the years 1927-28 members of the Association were asked to complete Questionnaire of Personal Information and nineteen hundred and eighty-four forms were completed and forwarded to me for safe keeping. A complete list of these forms with name and town address has recently been made in duplicate, one list has been forwarded to your Secretary and one has been filed in the McGill Medical Library along with a number of Archives of the Association.

At a meeting of your Committee held on April 23rd, 1937, it was decided to recommend that, a ten-year period having lapsed since the Questionnaires were sent out, additional forms should be sent to those members of the Association whose names do not appear on the list.

We have not had a very great demand for the completed forms during the past ten years but on a few occasions they were found to be of considerable interest and it is felt by your Committee that as time passes these Questionnaires will be found to be increasingly valuable.

Your Committee has continued to collect material for the archives and these consist chiefly of biographical newspaper clippings.

All of which is respectfully submitted.

C. F. WYLDE,
Chairman.

Approved.

REPORT OF THE EXECUTIVE COMMITTEE

Mr. Chairman and Members of the General Council:—

Your Executive Committee has held two meetings since its election last June, one in Victoria on June 25th, and one in Ottawa on October 29th and 30th, 1936. Another meeting will be held prior to the convening of the General Council in Ottawa.

ANNUAL MEETING, 1936

The Annual Meeting in Victoria, B.C., in 1936, was one of the most enjoyable we have ever held. The Canadian Medical Association has met twice in this beautiful city, the first time in 1926 and then again, just ten years later, in 1936, and we feel sure that all those present on either or both occasions will agree that no more ideal location could be found for a convention. The excellent

program and genuine hospitality of our Victoria colleagues made the week spent there one long to be remembered.

ANNUAL MEETING, 1937

Our Annual Meeting this year is being held jointly with the Ontario Medical Association. Under the direction of Dr. T. H. Leggett, President-Elect of the Canadian Medical Association and Dr. R. K. Paterson, President-Elect of the Ontario Medical Association, a strong Committee has been hard at work for many months, preparing for the forthcoming meeting in Ottawa, and we know that no effort has been spared to make this joint convention an outstanding success in every way. To all members of the Committees in charge, including the Ladies' Committee and the Junior Committee, we extend sincere thanks. We feel confident that our appreciation will be voiced by all who attend the meeting.

MEDICAL ECONOMICS

In the report of the Committee on Economics, as presented at the Victoria meeting in 1936, it was recommended that the Association appoint a full time medical man in charge of medical economics, whose duty it would be to secure up-to-date information on Health Insurance, and be prepared to assist the Provincial Medical Associations in all such studies. The General Council, while realizing the need for this action, was unable to face the expenditure that would be required, and therefore, amended the report in such a way as merely to express an opinion in favour of such a measure. With this as a guide, the Executive Committee last October asked the General Secretary to devote a portion of his time to Secretarial duties connected with the problem of medical economics. In order to secure authentic information on the subject, he was authorized to visit the British Isles, Denmark, Belgium, Germany and France, to make a study of the actual operation of health insurance in those countries.

It is the opinion of your Executive Committee that, by this intensive study, a vast amount of information will be obtained as to the advantages and defects of the different systems in operation, which will be of value to the Canadian Medical Association in its endeavour to assist the various provincial associations in effecting a solution of the economic problem of medical service. At time of going to press, the General Secretary is still in England engaged in this special work.

CODE OF ETHICS

Two years ago, Dr. D. A. Stewart, of Ninette, was asked to assume the chairmanship of the Committee on Ethics and to undertake the work of revising the Code of Ethics of the Association. Last year, this Committee made a progress report, expressing the hope that another year would see the completion of their task. Unfortunately, Dr. Stewart was taken very ill and passed away last February, leaving the work in which he took such a deep interest not quite finished. A short time before, knowing that his strength was failing and that he would never see the revision of the Code actually accomplished, he asked Dr. Ross Mitchell, of Winnipeg, a member of his committee, to carry it through and prepare the report for the General Council. Dr. Mitchell's report appears in this booklet.

Your Executive Committee desires to record its appreciation of the splendid work done by Dr. Stewart on this Committee, and our keen sense of the loss the Association has sustained in his passing.

HISTORY OF THE CANADIAN MEDICAL ASSOCIATION

Nearly two years ago, Dr. H. E. MacDermot, of Montreal, completed the compilation of the History of the Canadian Medical Association. A number of volumes have been sold at $3.00 each but copies are still available. For the convenience of doctors attending this meeting, orders may be left at the Registration Desk.

FEDERATION

The Alberta Division has now entered its second year as the Alberta Division of the Canadian Medical Association, bringing into federation 536 members.

A study committee has been appointed in each of the other provinces. It is evident that, in all the provinces the principle of federation is approved, but many details will have to be worked out in order to arrive at a plan that will be satisfactory to all.

BLACKADER LECTURE

The Blackader Lecture which is given triennially at the annual meetings of the Association will be delivered this year by Dr. H. B. Cushing, of Montreal. This Lecture was first presented in Vancouver in 1931, by Dr. Edwards A. Park, Professor of Pædiatrics, Johns Hopkins University, Baltimore; and next, in Calgary in 1934, by Dr. A. J. Craigie, Lecturer in Epidemiology and Research Associate, Connaught Laboratories, University of Toronto.

MEMBERSHIP AND SUBSCRIPTIONS

At the time of going to press, our membership and subscriptions stand as follows:—

Province	*Membership* 1936	1937	*Subscriptions* 1936	1937
British Columbia	381	368	10	13
Alberta	528	536	7	8
Saskatchewan	231	219	6	5
Manitoba	173	165	7	14
Ontario	963	1,617	265	229
Quebec	345	347	45	49
New Brunswick	120	134	4	2
Nova Scotia	127	237	6	7
Prince Edward Island	22	29	..	..
United States	36	16	269	260
Miscellaneous	..	14	60	69
	2,926	3,682	679	656

At the October meeting of the Executive Committee a lengthy discussion took place with reference to the advisability of establishing a conjoint membership fee for those provinces desiring it, this fee to include membership in the Canadian Medical Association and the Provincial Association.

The representative on the Executive Committee from the Province of Nova Scotia brought the suggestion from his province that they would put on an intensive campaign in an endeavour to secure 250 members for the C.M.A. if the C.M.A. would allow the Provincial Association a remittance of $2.00 on each membership secured, for collection. This would give the C.M.A. 250 members in Nova Scotia instead of 130 which they had in 1936. We are pleased to announce that we have to date received from the Nova Scotia Medical Society remittances to cover C.M.A. membership for 236 doctors in that province. Last year, our C.M.A. membership in Nova Scotia was 130. It will be observed that the membership in Ontario stands at 1617 which is a gain of 654 over last year.

Representatives from the Province of Ontario then made the suggestion that they attempt to secure 1,500 C.M.A. members in that province on the understanding that if successful they would receive a remittance similar to that suggested by Nova Scotia.

The Executive Committee finally agreed, as a trial measure for the year 1937 only, to grant the requests of the Provinces of Nova Scotia and Ontario.

CANCER

For several years, the Study Committee on Cancer has been making careful studies in the hope that something might be done to lower the terrible mortality from this disease in Canada. It was evident from the outset that, pending the discovery of the cause of cancer, success could be attained only through an educational campaign of national scope which would include physicians and the public at large. To this end, the Board of Trustees of the King George V Silver Jubilee Cancer Fund has recently made an annual grant of $14,000 to the Canadian Medical

Association. The grant carries with it the provision that the Canadian Medical Association will take the initiative in the formation of a national organization of laymen and physicians to combat the cancer scourge.

It is scarcely necessary to say that the Canadian Medical Association has accepted a heavy responsibility. At the same time, it has been given an unusual opportunity to render a great public service. Success will depend not only on medical organization, but also on the individual cooperation of its members.

Dr. J. S. McEachern, the tireless Chairman of the Study Committee on Cancer, well deserves our congratulations for the part he has played in this forward step in the fight against cancer.

ANNUAL MEETINGS OF THE PROVINCIAL ASSOCIATIONS

In the month of September, 1936, the President, Dr. Hermann Robertson and Mrs. Robertson, along with the General Secretary, visited the annual meetings of the Provincial Medical Associations in New Brunswick, Nova Scotia and Prince Edward Island, including also the first meeting of the Canadian Medical Association Alberta Division.

Arrangements are now being made for a team of scientific speakers to visit the Provinces of Saskatchewan, Alberta and British Columbia next September, in company with the President-Elect, Dr. T. H. Leggett, and the General Secretary. We are still following the plan adopted at the cessation of the Sun Life grant, of sending a team of speakers on scientific subjects, in alternate years, to the Western Provinces and the Maritimes. We would express the hope that economic conditions will so improve that it will be possible for us, in the near future, to revive our post-graduate activities, even if it were necessary to do so on a modified scale.

CONCLUSION

In addition to the foregoing items, a great many matters of lesser importance have engaged the attention of your Executive Committee during the year.

In conclusion, we desire to express, on your behalf, sincere thanks to all committees and individual members who have assisted in connection with the various activities of the Association during the past year.

All of which is respectfully submitted.

GEO. S. YOUNG,
Chairman.

T. C. ROUTLEY,
General Secretary.

Approved.

SUPPLEMENTARY REPORT OF THE EXECUTIVE COMMITTEE

The General Secretary presented a supplementary Report of the Executive Committee, dealing with the following matters.

MEDICAL RELIEF

At the meeting of the Executive Committee held on Friday and Saturday, June 18th and 19th, notice was taken of a communication sent by the General Secretary to the Honourable Mr. Dunning, Minister of Finance for Canada, calling attention to the need for medical care in the drought areas of Western Canada. The attitude of the Government was set forth by the Honourable Mr. Dunning in his reply, in which he states that the Federal Government is assisting the Provinces in providing relief for the unemployed—that is, food, fuel, clothing and shelter—and that, in his opinion, there is no reason why the Provinces should not undertake, on their own behalf, the provision of medical care for these people. He pointed out that, in all matters of relief, the municipality is primarily responsible and, then, the Provincial Government. It was felt by the Executive Committee that an attempt should be made to bring it to the consciousness of the Dominion Government that their present plan should be changed and that the medical profession should not be required to provide medical care for people in the drought areas of the prairie provinces without adequate remuneration.

Following discussion by the Executive Committee a sub-committee was appointed to draft a resolution regarding this matter, for presentation to the General Council.

The sub-committee later brought in the following resolution to Council:

"WHEREAS the Honourable the Federal Minister of Finance has stated that Federal Relief Funds cannot be used for the provision of medical care, and it is held that, under the British North America Act, this care should be provided by the Provinces: and

WHEREAS certain provinces, particularly those with drought areas, maintain that, even with Federal assistance for other forms of relief, they are unable to provide medical care, and insist further that this care is a municipal obligation; and

WHEREAS the federal and provincial governments are leaving this care wholly or in part to municipalities which have no funds and have thus placed the burden upon doctors who, in many instances have no other source of livelihood;

BE IT RESOLVED—

1. THAT, in the provision of assistance to provinces in connection with their relief programs, the Federal Government should, without further delay, recognize medical relief as of equal importance with the provision of shelter, food, fuel and clothing; and, furthermore,
2. THAT the relief of the suffering of people is of more importance than the maintenance of a debatable legal position and must be provided by that section of the Government which is best able to do so." *Carried.*

Following the meeting, the above resolution was sent to the Honourable C. A. Dunning, Minister of Finance, The Right Honourable W. L. Mackenzie King, Prime Minister of Canada, and The Honourable C. G. Power, Minister of Pensions and National Health.

FEDERATION

At the meeting of the Executive Committee attention was called to the following resolution passed by the Ontario Medical Association on June 2, 1937:

That this Council of the Ontario Medical Association request the Board of Directors to take the necessary steps to bring about federation with the Canadian Medical Association, provided our local autonomy is fully preserved and the objections cited in the report of the Committee on Federation are rectified; and provided that this plan shall be presented to and approved by Council and the members of the Ontario Medical Association.

The objections to which reference was made in the report of the O.M.A. Committee on Federation are as follows:

1. That the provincial branches should appoint members to the Council of the C.M.A.

It was pointed out that this is now the case.

2. With regard to the striking of the Committee on Nominations, each provincial branch should appoint its allotted number. It is not agreed that this Committee should be appointed by the General Council.

Council discussed this point very carefully and it was finally agreed that the Constitution and By-Laws for Divisions should be amended to state that candidates for election to the Nominating Committee shall be named from the floor and the list shall include the names of one or more members of each branch or division if represented at this session; but a division, through an accredited representative present, may elect one member on the Nominating Committee.

3. That the Secretary, the Editor, and the Managing Editor of the *Canadian Medical Association Journal* be members of the Executive Committee without voting power.

Council agreed that Article VIII, Section C, of the Constitution and By-Laws should be amended by the addition of the following sentence: "The appointive officers shall have no voting power".

4. That branches be not obliged to be responsible for the payment of the fees of their members to the C.M.A.

5. That no attempt be made to secure members through coercion.

The two provisions mentioned above were very carefully considered by Council and a number of suggestions were made, all of which will be considered by the Executive Committee in an endeavour to arrive at a plan which will be satisfactory to all concerned.

In order to expedite the discussion of difficulties in the way of Federation in the different provinces, the following resolution was approved by Council:

THAT WHEREAS certain difficulties have arisen in the development of plans for federation between the Canadian Medical Association and the provincial Associations; and

WHEREAS these differences could best be discussed by the executive of the various provincial Associations and representatives of the Canadian Medical Association;

THEREFORE BE IT RESOLVED THAT the Executive of the Canadian Medical Association be asked to meet with the executive of any provincial Association asking for such consultation, for the purpose of adjusting any differences that may exist.

ASSOCIATE SECRETARIES AND REGIONAL SUB-EXECUTIVES OF THE C.M.A.

The suggestion was made that it would be advantageous if Canada were divided into a number of Regional Districts, in each of which there would be a sub-executive of the C.M.A. and also an Associate Secretary. It was pointed out that in these Sub-Executive meetings matters of local importance could be very thoroughly discussed before bringing them to the attention of the C.M.A. Executive Committee. It was agreed that this whole matter should be very carefully studied by the Executive Committee, and that a report be made at a later date.

AFFILIATION WITH THE CANADIAN RHEUMATIC DISEASES ASSOCIATION AND THE HEALTH LEAGUE OF CANADA

Applications for affiliation were received from the Canadian Rheumatic Diseases Association and the Health League of Canada, both of which were approved, provided the Constitution and By-Laws of each is found by our Committee on Constitution and By-Laws to be satisfactory.

PATRONAGE OF HIS MAJESTY THE KING

It was reported for the information of our members that His Majesty King George VI has granted his patronage to the Canadian Medical Association.

BRITISH MEDICAL ASSOCIATION *re* CHEMICAL WARFARE

The following resolution passed by the Representative Body of the British Medical Association was presented to the Executive Committee:

"That this meeting condemns unreservedly the use of poison gas in warfare, as inhuman in its results and degrading to civilization."

Council resolved that a similar resolution should be spread upon the Minutes of this meeting.

THE NATIONAL RESEARCH COUNCIL

During the year conferences have been held between representatives of the Canadian Medical Association and the National Research Council with regard to the advisability of forming a Medical Research Committee. As a result of these conferences, the following recommendations were presented to Council:

1. That the Canadian Medical Association is keenly interested in the formation of an Associate Medical Research Committee under the ægis of the National Research Council, and such action might be considered the first step toward the creation of a Medical Research Council for Canada.

2. That the Committee of the Privy Council for Scientific and Industrial Research be petitioned to authorize the National Research Council,
   (*a*) to set up an Associate Committee for medical research;
   (*b*) to provide the money necessary to engage a full-time secretary and clerical assistance for the work of the Associate Committee, and travelling expenses of members in attending the meetings;
   (*c*) to provide also office accommodation, library, and other facilities to advance the work of the committee;
   (*d*) to convene a conference of representatives of interested bodies, *viz.*: Faculties of Medicine, Medical Research Institutions, apart from Medical Schools; Dominion and Provincial Departments of Health; and nationally organized medical associations, *i.e.*, Canadian Medical Association and Royal College of Physicians and Surgeons of Canada. The function of this conference would be to nominate to the National Research Council the personnel of the Associate Committee on Medical Research and to outline the scope of its duties and responsibilities.
3. That these resolutions shall be forwarded to the Prime Minister of Canada, with copies to the Minister and Deputy Minister of Pensions and National Health, and to the President of the National Research Council for their information.
4. Also, that a copy of these resolutions be sent to the Deans of all Medical Faculties in Canada and to the Royal College of Physicians and Surgeons of Canada for information and such action as they may see fit.

These recommendations were approved by the General Council.

SENIOR MEMBERSHIP

The General Council approved of senior membership in the Association being conferred upon the following: Dr. R. E. McKechnie, Vancouver; Dr. S. E. Fleming, Sault Ste. Marie; Dr. J. K. McLeod, Sydney.

HONORARY MEMBERSHIP

The General Council approved of honorary membership in the Association being conferred upon the following: Sir Harold Beckwith Whitehouse, Birmingham; Mr. Watson Jones, Liverpool; Dr. Antoine Lacassagne, Paris.

REPORT OF THE COMMITTEE ON CONSTITUTION AND BY-LAWS

Mr. Chairman and Members of the General Council:—

The following alterations in the wording of certain sections of the Constitution and By-Laws were approved by the Committee and are forwarded to the General Council with the recommendation that the Constitution and By-Laws be so amended:

1. *Article V*—which reads in part, as follows:

   Any Branch, if it so desires, may merge its identity in that of The Canadian Medical Association and become a Division. It shall then be known as The Canadian Medical Association.....(Name of Province) Division. All of its members shall be members of The Canadian Medical Association and shall be entitled to all the rights and privileges of membership.

   It is suggested that "may merge its identity in that of", be changed to read, "may change its relationship to."

2. *Chapter V, Section 1*—which reads in part, as follows:

   The General Council, at the first session of the annual meeting, shall elect by ballot from among its members present a Nominating Committee of fifteen members not including the President who shall be *ex-officio* Chairman of the Committee.

   It is suggested that the last two lines be changed to read as follows:

   "fifteen members not including the President and General Secretary who shall be respectively *ex-officio* Chairman and *ex-officio* Secretary of the Committee."

3. *Chapter V, Section 3*—which reads as follows:

   When the report of the Nominating Committee has been received by the General Council in session, other nominations may also be received from the floor. A ballot shall then be taken for each of the offices in turn and also for elective members of the Executive Committee by provinces in accordance with the By-Law for the guidance of the Nominating Committee, Chapter V, Section 2, paragraph 2.

   It is suggested that the following sentence be added to this Section.

   "In case of a tie vote, the Chairman shall have the casting vote."

4. *Chapter VIII, Section 2*—which reads as follows:

   All matters relating to medical legislation, Federal or Provincial, and all matters requiring legislative *action* (made or contemplated) arising within The Association, or any of its branches, or any of its committees, shall be referred to the Committee on Legislation for information and for any necessary action.

   It is suggested that the word "action" be changed to "necessary advice".

5. *Chapter VIII, Section 8* (*b*)—which reads as follows:

   It shall be the duty of this Committee to keep the public informed through the various means available, on matters pertaining to health.

   It is suggested that the words, "subject to the approval of the General Council" be inserted after the word "Committee".

6. *Chapter VIII, Section 10*—which reads as follows:

   It shall be the duty of the Committee on Economics, (excepting where otherwise provided) to deal with (*a*) social legislation which includes medical services or benefits presumably for medical services; (*b*) remuneration and employment of physicians by lay bodies, hospital or official bodies, including Federal, Provincial and Municipal Governments.

   It is suggested that this be changed to read as follows:

   "It shall be the duty of the Committee on Economics, (excepting where otherwise provided) to advise the General Council upon (*a*).....Governments."

All of which is respectfully submitted.

R. I. HARRIS,
Chairman.

Approved.

REPORT OF THE COMMITTEE ON CREDENTIALS AND ETHICS

Mr. Chairman and Members of the General Council:—

I have the honour to submit the report of the Committee on Credentials and Ethics of the Canadian Medical Association.

In 1936, Dr. David A. Stewart, Chairman of the Committee, published two articles in the *Canadian Medical*

Association Journal: "The Ethics of Medical Practice; (1) Should the Code be Revised? (2) Ancient Rules and Modern Rulings." On August 21, 1936, Dr. Stewart submitted to the members of the Committee and also to a few physicians not on the Committee, notably Dr. Alfred Cox, former Secretary of the British Medical Association, and Dr. James Grassick of North Dakota, the first draft of a new Code, together with the Oath of Hippocrates and the Prayer of Maimonides. Comments on the new code were invited and came in from many quarters.

In September, 1936, Dr. Stewart was admitted to the Winnipeg General Hospital for what was thought to be a simple operation. This expectation was not realized; other operations were necessary, and after much suffering and the anguish of losing his beloved wife in November, Dr. Stewart passed away on February 16th, 1937.

During the early days of his stay in hospital he had edited the great majority of the replies received from members of the Committee and others and had had stencils prepared for multigraphing these comments. In January he requested me as a member of the Committee and a friend of forty years' standing to carry on the work, and outlined changes which he considered should be made in the first draft of the Code of Ethics.

In April of this year copies of the second draft of the Code were sent to members of the Committee, to the Secretary of the Canadian Medical Association for transmission to members of the Canadian Medical Association Executive Committee, and to the few physicians outside the Committee who had commented on the first draft.

This second draft, a copy of which is included in this report, is respectfully submitted to the Council of the Canadian Medical Association for consideration. While minor changes have been made, the Code is practically the work of the late Chairman, Dr. D. A. Stewart, and reflects his high idealism, his jealousy for the honour of the profession, his love of the medical classics and his fine literary style. It is an attempt to apply the ideals of the fathers of our profession to the conditions of the modern practice of medicine.

SECOND DRAFT OF NEW CODE OF ETHICS OF THE CANADIAN MEDICAL ASSOCIATION

> He should be modest, sober, patient, prompt to do his whole duty without anxiety; pious without going so far as superstition; conducting himself with propriety in his profession, and in all the actions of his life.
>
> —*Hippocrates.*

Introductory

"As ye would that men should do to you, do ye even so to them," is a Golden Rule for all men. A Code of Ethics for physicians can only amplify or focus this and other golden rules and precepts, such as those of the fathers of our Art, to the special relations and interrelations of their practices. A stream cannot rise above its sources: so a code cannot change a low-grade man into a high-grade doctor, but it can help a good man to be a better and more enlightened man, and doctor. It can quicken and inform a conscience, but can scarcely create one. It cannot say in many things "thou shalt" or "thou shalt not", but in many things "thou shouldst" or "thou shouldst not".

While the highest service they can give humanity is the only worth-while aim for men of any profession, it is this with a special particularity for the physician, in that his services apply immediately and directly to the health of the bodies and the minds of men. A good physician is a great citizen.

> Show thy art in honesty, and lose not thy virtue by the bad managery of it.
>
> —*Sir Thomas Browne.*

Of the Duties of Physicians to Their Patients

For the honourable physician the first consideration will always be the welfare of the sick. On his conscience rests the comfort, the health, the lives of those under his care. To each he gives his utmost in science and art and human helpfulness. Their confidences are safe in his keeping, except when the safe-guarding of society imposes a higher law. He will not multiply costs without need, nor raise fears needlessly, nor allay fears without full consideration. Even when he cannot cure he will alleviate and be counsellor and friend.

It is a special duty for one who stands guard over the lives of men to keep his science and his art in good repair, to enlarge and refresh his knowledge constantly, and give his patients treatment that is not only sympathetic but as near as it can be to the utmost for the time and the place. To this end he will always be willing to check and supplement his diagnosis, treatment and prognosis by consultation. No excellencies in a physician can excuse slipshod or ignorant or out-dated service.

Every patient is entitled to full examination by the physician. To be thorough is better than to be brilliant. The physician should aim to give to his patient the same type of service which he hopes in time of need for himself or his family to receive from another physician.

If a practitioner is confining his study and practice to some special branch he must be sure that his special knowledge and outlook are suited and adequate to all the needs of the sick person under his care. He must see that the sick person will have not only all that he has to give, but all that there is to get.

In short, the whole study and care of the honourable physician is in the greatest well-being of the sick person.

> The greatest trust between man and man is the trust of giving counsel. —*Francis Bacon.*
>
> Whatsoever thy hand findeth to do, do it with thy might. —*Ecclesiastes.*
>
> Loving care is not enough: it must be skilful as well. —*French.*
>
> The master-word is work. —*Osler.*
>
> Remember that I too am mortal. —*Bernard Shaw.*

Of Professional Services of Physicians to Each Other

Usually it is unwise for a physician to treat himself or members of his household in any serious illness, and help will always be readily given by any other physician. Though such services are given freely and cheerfully, and should be, yet if out-of-pocket expenses have been incurred, or if there has been loss through considerable absence, these should, if possible, be made good, at least in part.

If in such illnesses, because of friendship, or to give advantages of special skill or experience, several brethren of the profession visit the sick physician or dependent, it must be made clear that some one designated physician has definite responsibility for the carrying on of the treatment.

> Fear not to be outdone by mercy.
>
> —*Sir Thomas Browne.*
>
> Live by the old ethics and the classical rules of honesty. —*Sir Thomas Browne.*

Of the Duties of Physicians Regarding Consultations

In any illness that is serious, obscure or difficult, or one in which there is especial responsibility, or when consultation is desired by the patient or his friends, the attending physician should request a consultation. While he should suggest consultants he prefers, he should be ready to meet the patient's choice if qualified in the existing situation.

If a physician is called to treat an illness in connection with which medico-legal questions are likely to arise, *e.g.*, poisoning, criminal abortion; consultation should be considered obligatory.

Since every consultation is planned wholly for the good and advantage of the sick person, there should enter into it no trace of insincerity, rivalry or envy. "A consultant should refrain from those extraordinary attentions and assiduities practised by the dishonest." (Old Code.) After joint examination, the physicians should discuss

the case by themselves, then the joint decision should be communicated to the patient and his family by the attending physician, supplemented if necessary, by the consultant. Honesty and candour should pervade the discussion. If it is impossible for the attending physician and the consultant to make their examinations at the same time, the consultant's conduct must be especially careful and tactful. The responsibility for the patient's care is with the physician in attendance. If he should retire from the case, the consultant must not replace him during the present illness, except at the attendant's request or with his approval.

Patients Referred to Physicians, Specialists or sent to Hospitals

The duty of a consultant to report findings and discuss them with the attending physician, so that he may have all possible advantage from the consultation, is equally binding, and should never be omitted, when the patient has been sent from a distance, either for office examination or admission to a hospital under the consultant's care, and whether on a paying or a non-paying basis. It is equally the duty of the physician referring a patient to give as full information as possible. A hospital physician should see that findings or suggestions of value concerning any patient now under his care in hospital, are sent to the physician usually in charge. In the free ward services the hospitals should provide facilities for the sending of such reports, and share responsibility for their sending.

A Physician as a Visitor

When a physician, as a personal friend, meets the patient of another physician, or calls upon him when ill, he must be careful not to be drawn into interference through suggestions or opinions unless called in consultation in the authorized way.

> Teach the tongue to say, I do not know.
> —*Maimonides.*

> Study thou the Dominion of thyself, and quiet thine own commotions.—*Sir Thomas Browne.*

> Let no back-biting or tale-bearing man sit here.
> —*Saint Augustine.*

> Let him be tender with the sick, honourable to men of his calling. —*Ambrose Pare.*

Of the Duties of the Individual Physician to the Profession at Large

The physician should be jealous for the honour of his craft, for its devotion to truth, its disinterestedness, and for the maintenance of its services to mankind at the highest level. No profession or calling should demand higher standards of integrity nor more constant devotion to the common good.

> I hold every man a debtor to his profession.
> —*Francis Bacon.*

Advertising

Except a plain card which conforms to local usages, any form of public advertisement is entirely out of place and unprofessional, though a physician in a wholly official capacity, such as a Health Officer, must keep in touch with his constituency. Practice must not be gathered by any kind of solicitation, direct or indirect. The best advertisement of a physician is a well-merited reputation for ability and probity in his profession.

Advertising can be very insidious. A physician should not procure, sanction, be associated with, or acquiesce in, notices commending his own or any practitioner's skill, knowledge, services, qualifications, or depreciating those of others.

An honourable physician will never be guilty of boasting of cures or promising radical cures, or of self-laudation in order to gather practice.

Physicians should be extremely cautious in dealing with the Press. The Press has no concern with medical ethics. A physician should insist, wherever possible, on seeing a proof of what is to be printed under his name or on his authority.

"The practice of medical practitioners taking charge of columns in which answers to correspondents on medical questions are printed, is highly detrimental to the public interest and most improper from a professional point of view." (British Medical Association's Decisions.)

Discoveries

No advance or discovery in any branch of medical science made by a physician should ever be capitalized or marketed by him in any way for gain, or kept secret for his private advantage, but must be made common for the advantage of the whole profession, and the advancement of science. There are well recognized methods by which physicians can place their work and discoveries before those who are fitted by education and experience to criticize them. The lay press is not the proper medium for the first announcement of a physician's work or discoveries.

Paid Advocacy

The paid advocacy of any commodity, whatever its merits, cannot be reconciled with the ideals of the physician. He must be a free agent to choose out of all elements the best possible for his patient, and not a merchandiser, pushing one particular element for gain. It is his being a physician that gives his advocacy its extra market value, so while he sells a commodity he sells also, it may be for thirty pieces of silver, that which is not his to sell, the common tradition and inheritance of reputation, esteem and standing of the whole profession.

Secret Commissions

A secret arrangement between two physicians whereby, unknown to the patient, one physician receives part of the fee due to the other is not consistent with the dignity of the profession. Such a practice is dishonest and leads to trafficking in patients. The physician to whom the patient is referred may request the services of the referring physician, *e.g.*, as anæthetist or assistant, and if the patient assents to the request, a fee may be charged by the referring physician for the services rendered. Occasions may arise when the complexity or obscurity of an illness demands the services of physicians practising different fields of medicine. In such case a composite fee may be arranged and distributed. Providing the patient is informed before hand of this arrangement, the division of the composite fee does not conflict with the ethics of the profession.

The receiving of commissions connected with the sale of a commodity or with the referring of patients is entirely unethical conduct.

Medical Associations

A physician should associate himself with local, provincial and Canadian medical societies, to promote his own and the general advancement in our science and art.

Group Practice and Ethics

Whatever is right and becoming in a physician is equally right for any association of physicians in clinics or other groups, and whatever is obligatory upon the individual is equally obligatory upon the group.

Emergency Calls

When a physician is called in the absence of the attending physician, or in emergency, he will, on the arrival of the attending physician, hand over all care and responsibility, and retire from the case.

When in a case of sudden illness or accident several physicians are called, the first to arrive should be considered to be in charge. However, he should withdraw in favour of the regular family attendant should he arrive, or of any other physician the patient prefers.

Locum-tenency

A physician who has been locum-tenent should not begin practice in the same neighbourhood unless with the written consent of the practitioner he has substituted for or after the lapse of considerable time.

Contract Practice

Contract practice, while not in itself unethical, becomes so if there is solicitation for patients, underbidding, interference with the choice of physician, if the compensation is so low that adequate service cannot be given, or if professional services are made to yield profits to controlling lay groups.

Differences between Physicians

Differences between physicians that cannot be adjusted by fair discussions should be referred to the Committee on Ethics of the local medical society. Complaints about unprofessional conduct should be referred to the same committee, in writing, signed.

> Let not the sun in Capricorn go down on thy wrath. —*Sir Thomas Browne.*
>
> Good intentions are at least the seeds of good actions. —*Sir William Temple.*
>
> I prefer to attribute high motives to my friends' acts. —*Pasteur.*
>
> Though the number of thine ears should equal Argus his eyes: yet stop them all with a wise man's wax, and be deaf unto the suggestion of tale-bearers. —*Sir Thomas Browne.*

Medical Witnesses

It is advisable that medical witnesses should confer and if possible reach an understanding about facts, however they may differ in opinions based on the facts. The medical witness should be actuated by a desire to assist the court to arrive at a just decision and not merely to advance the interests of the party by whom he is summoned.

Patent Preparations

"A physician should not make use of, or recommend, any remedy, the principal ingredients of which are not disclosed to the professions." (British Medical Association's Decisions.)

Succeeding another Physician

A physician is not free to assume care of a patient who has had another attendant, in the present illness, unless or until he has satisfied himself that those responsible have notified the other attendant that his services are no longer required.

Care in Comment

When one physician succeeds another in the care of a patient he should make no adverse comments upon the treatment already given.

OF THE RELATIONS OF PHYSICIANS IN AND WITH HOSPITALS

A hospital on the modern plan is a new element in the care of the sick, and may not yet have become rightly adjusted in all its relations. Mutual understanding and cooperation between the profession and the hospitals is most essential.

Inasmuch as the free service rendered by an honorary attending staff is a contribution of the whole profession to charity and to education, the organized profession should be recognized in the selection of such staffs.

And inasmuch as such honorary positions give to those who hold them unique opportunities for enlarging knowledge, they should be held as a trust for the profession, for the advancement and teaching of medical science and for the general good of the community.

Such appointments, while applied for, should not be canvassed for, and should never be given on account of party or favouritism but solely on account of professional standing, industry, the spirit of cooperation and the ability and willingness to teach.

The appointment of paid or part paid staffs in public hospitals or of professors in medical colleges should be made on the same principles.

The Services

No hospital, especially no lay board, has a right to dispose of the free services of physicians except as approved by the organized profession. It is the duty of hospital boards or executives to see that the free services of physicians are not asked for, or given to, or exploited for those who can and should pay, or for whom payment should be made.

While what have been called God's poor should always be cared for with charity, the growing numbers of what might be called the state's poor, or the state's wards, should be cared for on some basis that allows proper remuneration for services. No special profession or class, except by courtesy, no endowed institution or mutual benefit association can rightly claim free services.

Nurses and Nursing

A new profession of nursing has grown up to share in the care and prevention of illness, and the bettering of general health. In this whole large area the services of the two professions, being complementary to one another, are, and must be, closely inter-related. If the spirit in both doctors and nurses is one of courtesy, understanding, appreciation, mutual helpfulness, cooperation and zeal for the welfare of the people, misunderstandings should not arise, or if they do, should be quickly cleared up.

Non nobis solum

> The care of the sick is to be placed above and before every other duty as if, indeed, Christ were being directly served in waiting on them. —*Saint Benedict.*
>
> I insist, brothers, that those who have to do with the care of the health of the brethren who have come into the sacred places from the world should fulfil their duties with exemplary piety. —*Cassiodorus.*

OF THE DUTIES OF THE PROFESSION TO THE PUBLIC

The vision of the good physician should reach beyond the welfare and cure of persons to the welfare and cure of humanity. The New Medicine is social as well as clinical, with new ways of distribution to the needs of the people. Its new wine has burst the old bottles of individual bargaining. The New Medicine asks how the utmost possible in service can be made most widely and instantly available, reaching beyond those who ask to those who need but do not ask and to those who need yet do not know they need. Any wastage or leakage of health or life anywhere is a challenge to our profession. Our public health measures, local and general, are practical humanitarianism, influences for race betterment potent as the world has known. Every physician, whatever his special training, should be officially or unofficially an officer of the state for the betterment of health. It is our privilege to be preventers of disease as well as curers, statesmen and ambassadors of health, planners of new worlds, counsellors of the people of a new day.

General Principles

Any general medical service for a nation should aim to prevent no less than cure disease, guard individual choice of doctor, provide consultant and specialist services, put regulation of the quality of professional services upon the profession, interpose as little as possible between doctor and patient, advise with the organized profession and, if possible, arrange for nursing and hospital care.

There is nothing that can be urged rightly for the advance of medicine or for the higher ideals and higher standing of the profession of medicine that is not in the long run for the greater good of the people at large.

NOTE.—This Code is intended to give the general principles of the Ethics of the practice of Medicine in short compass. For detailed discussion of some points reference may be made to the decisions of the Canadian Medical Association or, with allowance for different circumstances, of the British Medical Association.

It is the Art and the Mission of Medicine to take all that is known in fact and science and apply it skilfully, wisely, gratefully and beautifully to the needs of sick people, and to the ways of life for men and nations.

It was said of Pasteur that he tried to cure not persons, but humanity.

Medical science extends the boundaries of Life.
—*Pasteur.*

The New Medicine puts in the hands of people the power to redeem themselves.
—*Sir George Newman.*

Though a cup of water from some hand may not be without its reward, yet stick not thou for Wine and Oil for the wounds of the Distressed. —*Sir Thomas Browne.*

There abideth Faith, Hope, Love, these three, and the greatest of these is Love.
—*Saint Paul.*

THE OATH OF HIPPOCRATES

I swear by Apollo Physician, by Asclepios, by Health, by Panacea and by all the gods and goddesses, making them my witnesses, that I will carry out according to my ability and judgment this oath and this indenture. To hold my teacher in this art equal to my own parents; to make him partner in my livelihood; when he is in need of money to share mine with him; to consider his family as my own brothers, and to teach them this art, if they want to learn it, without fee or indenture; to impart precept, oral instruction, and all other instruction to my own sons, the sons of my teacher, and to indentured pupils who have taken the physician's oath, but to nobody else. I will use treatment to help the sick according to my ability and judgment, but never with a view to injury and wrong-doing. Neither will I administer a poison to anybody when asked to do so, nor will I suggest such a course. Similarly I will not give to a woman a pessary to cause abortion. But I will keep pure and holy both my life and my art. I will not use the knife, not even, verily, on sufferers from stone, but I will give place to such as are craftsmen therein. Into whatsoever houses I enter I will enter to help the sick, and I will abstain from all intentional wrong-doing and harm, especially from abusing the bodies of man or woman, bond or free. And whatsoever I shall see or hear in the course of my profession, as well as outside my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets. Now if I carry out this oath, and break it not may I gain for ever reputation among all men for my life and for my art; but if I transgress it and forswear myself may the opposite befall me.

THE PRAYER OF MAIMONIDES

(in part)

Almighty God! With infinite wisdom has Thou shaped the body of man. Ten thousand time ten thousand organs has Thou put within it that move in harmony and without ceasing to keep in all its beauty the whole—the body, the envelope of the immortal soul. .

To man hast Thou given the wisdom to soothe his brother's sufferings, to know his disorders, to extract what substances may heal, to learn their powers, and prepare and use them suitably for every ill. . . . .

Inspire in me a love for my Art and for Thy creatures. Let no thirst for profit or seeking for renown or admiration take away from my calling. . . . . Keep within me strength of body and of soul, every ready, with cheerfulness, to help and succour rich and poor, good and bad, enemy as well as friend. In the sufferer let me see only the human being.

If those should wish to improve and instruct me who are wiser than I, let my soul gladly follow their guidance: for vast is the scope of our Art.

In all things let me be content in all but the great Science of my calling. Let the thought never arise that I have attained to enough knowledge, but vouchsafe to me ever the strength, the leisure and the eagerness to add to what I know. For Art is great, and the mind of man ever growing.

Almighty God! In Thy mercy Thou has chosen me to watch beside life and death in Thy creatures. I now go to the work of my calling. In its high duties sustain me, so that it may bring benefit to mankind, for nothing, not even the least, can flourish without Thy help.

COMMITTEE ON CREDENTIALS AND ETHICS

1936 - 1937

Nucleus

Dr. D. A. Stewart (*Chairman*), Manitoba Sanatorium, Ninette, Man.
Dr. J. D. Adamson, 345 Yale Avenue, Winnipeg
Dr. A. T. Mathers, Medical College, Winnipeg
Dr. Ross Mitchell, Medical Arts Building, Winnipeg
Dr. A. F. Menzies, Morden, Manitoba
Dr. Walter Rogers, Dauphin, Manitoba
Dr. F. W. Jackson, Dept. of Public Health, Legislative Bldg., Winnipeg
Dr. W. W. Musgrove, Medical Arts Building, Winnipeg

Corresponding Members

Dr. C. H. Vrooman, 925 W. Georgia St., Vancouver
Dr. A. K. Haywood, Vancouver General Hospital, Vancouver
Dr. J. F. Brander, 502 McLeod Bldg., Edmonton
Dr. G. H. Malcolmson, McLeod Bldg., Edmonton
Dr. R. G. Ferguson, Fort San, Saskatchewan
Dr. D. F. McRae, Fort San, Saskatchewan
Dr. C. D. Farquharson, Agincourt, Ontario
Dr. Walter Hogarth, Fort William, Ontario
Dr. H. E. MacDermot, 1414 Drummond St., Montreal
Dr. A. H. Gordon, 1414 Drummond St., Montreal
Dr. Hugh Farris, Saint John, New Brunswick
Dr. K. A. MacKenzie, 89 Spring Garden Road, Halifax
Dr. F. W. Tidmarsh, 188 Prince Street, Charlottetown

All of which is respectfully submitted.

ROSS MITCHELL,
Acting Chairman.

It was agreed that this report should be referred back to the Committee for further study.

REPORT OF THE EDITOR

Mr. Chairman and Members of the General Council:—

This report covers the period from June 1, 1936, to May 31, 1937.

For considerations of economy the size of the *Journal* has had to be reduced. The letters from our overseas correspondents have been dispensed with, only temporarily we hope, and we are running about eight pages less. These changes came into effect with the January issue. It is to be remarked that the *quality* of the *Journal* has not deteriorated. Nevertheless we earnestly hope that the financial state of the Association will permit of a return to the former basis before many months.

Practically all of the papers read at the Victoria Meeting have been published. One or two have only reached the Editor very recently, hence the delay in their appearance. Contributors to the program are asked to hand in their manuscripts to the General Secretary or the Editor before the close of the Annual Meeting.

During the year 291 manuscripts were received, of which 37 were returned to their writers for various reasons.

We ask our members to see that their papers are double-spaced, with the references completed according to our specifications, and that they are in all respects ready for the printer. Attention to these points would save the editorial staff much time. Articles are being received from the United States in increasing numbers. Some of these are by Canadians living or working in the States, but not all. It would appear as if American doctors were looking to our *Journal* for an outlet. For the future we feel that we should restrict the number of such papers that we accept, in fairness to our Canadian workers.

The quality of the material offered for publication continues to be of a high order. We are fortunate, this year, in that we have had a number of papers of first class importance, some of which have broken new ground and others have attracted editorial notice abroad. Among these should be noted a careful study of silicosis, by Dr. J. T. Fallon, entitled "Specific Tissue Reaction to Phospholipids: a Suggested Explanation for the Similarity of Lesions of Silicosis and Pulmonary Tuberculosis", and "A Clinical Study of Silicosis", by Drs. H. H. Moore and M. J. Kelly, in the latter paper two new diagnostic signs being recorded. The new protamine zinc insulin of Drs, Scott and Fisher, of Toronto, has come in for attention. and its clinical application to man has been very fully set forth by Drs. I. M. Rabinowitch, J. S. Foster, A. F. Fowler, and A. C. Corcoran in two elaborate papers. Other notable contributions were "Hypertrophy of the Palpebral Tarsus, Facial Integument, and the Extremities of the Limbs, with widespread Osteo-periostitis—a new Syndrome", by Prof. J. N. Roy, of the University of Montreal; "The Effect of the Administration of Œstrogenic Hormones on the Nasal Mucosa of the Monkey", by Drs. H. Mortimer, R. P. Wright, and J. B. Collip; "Mental Disease following Carbon Monoxide Poisoning", by Drs. T. E. Dancey and G. E. Read; "Myasthenia Gravis", by Dr. H. H. Hyland; and a well illustrated series of papers on "The Radiological Treatment of Cancer", by Dr. G. E. Richards.

Other noteworthy contributions were "Internal Secretion as a Factor in the Origin of Cancer", by Prof. Leo Loeb and associates, of the Barnard Cancer Institute of St. Louis; and "Studies in Mineral Metabolism", by Dr. B. Chown. The disaster at the Moose River mine in Nova Scotia was dealt with by Drs. H. K. MacDonald, W. D. Rankin, and Ian MacDonald, who were on the spot and had first-hand information. The paper by Dr. Ian Macdonald appears to be the first and only one dealing with the matter of exposure and privation under these exceptional circumstances in a scientific way, and hence is particularly valuable.

In lighter vein was a delightful paper by Dr. E. P. Scarlett, entitled "Medicine and Poetry", which attracted considerable attention. Dr. E. W. Archibald's Fifth Listerian Oration on "The Mind and Character of Lister" was a characteristic and charming effort.

Rare cases described in the *Journal* were the following:—"A Case of Meningitis due to *B. Proteus*, with Recovery", by Dr. J. C. Calhoun; "Ventrally joined Twins", by Drs. C. B. Cameron and D. A. Campbell; "A Case of Alzheimer's Disease", by Dr. J. A. Hannah; "Mussel Poisoning in Nova Scotia", by Dr. A. L. Murphy; and "A Case of Infestation with the Corn Borer", by Dr. H. B. Church.

Following up an innovation introduced last year we have continued the policy of publishing a series of editorials dealing with live topics, bringing the various subjects up to date. These editorials have aroused favourable comment and we have received a number of requests for reprints, chiefly from the United States. Numerous requests have also been received for permission to publish certain articles, in whole or in part. It would seem that our *Journal* is being more widely appreciated every year. Topics dealt with editorially have been the action of certain drugs in causing vasodilatation, various phases of acute rheumatic fever, protamine zinc insulin, tuberculosis among college students, hygiene in colleges, and reform in medical education.

Under the section of "Medical Economics" the health insurance situation in British Columbia has been ventilated thoroughly, and attention has also been paid to the medical care of indigents in Ontario, and to some phases on the health situation in Quebec.

Books received during the year numbered 156, of which 68 were reviewed and 88 merely acknowledged. Canadian work noticed was the following:—"Atlas of Congenital Cardiac Disease", by Maude E. Abbott; "Dr. Dafoe's Guide Book for Mothers", by A. R. Dafoe; "The Quintuplets' First Year", by Louise de Kiriline; "The Practice of Medicine", by J. C. Meakins; "The Colon as a Health Regulator—from a Surgeon's Point of View", by Sir Henry M. W. Gray; "The Physiological Basis of Medical Practice", by C. H. Best and N. B. Taylor; and "Chronic Indigestion", by C. J. Tidmarsh.

Special notice has been taken of the passing of several of our late colleagues—Drs. Vaughan E. Black, Campbell P. Howard, Oskar Klotz, F. W. Marlow, F. A. C. Scrimger, A. D. Smith, and D. A. Stewart.

Our relations with our advertisers contine to be satisfactory.

Our personal thanks are tendered to the following whose assistance in so many ways has been highly appreciated:—to Dr. H. E. MacDermot, the Assistant Editor, and the other members of the Editorial Board; to the Chairmen of the Provincial Editorial Boards; to our Overseas Correspondents; to Drs. T. C. Routley, Harvey Agnew, H. W. Aikins, E. S. Ryerson, J. C. Simpson, and C. C. Macklin; to the Office Staff; to the Bureau of Investigation of the American Medical Association, and to the Murray Printing Company, whose ready cooperation we gladly acknowledge.

All of which is respectfully submitted.

A. G. NICHOLLS,
Editor.

Approved.

REPORT OF THE MANAGING EDITOR

Mr. Chairman and Members of the General Council:—

As the financial situation of the *Journal* is shown in the report of the Honorary-Treasurer there is no need for a detailed report by your Managing Editor.

The *Journal* expenditures have been limited by the exigencies of a budget imposed by the Executive Committee.

An increase in the number of advertisers is reported. These emanate chiefly from Canadian territory. During the year under discussion we had a total of 152 firms represented in our advertising pages. We have received every cooperation from them and accounts have been promptly met The latter is evidenced by the fact that out of a total advertising income of $30,461.08, only the sum of $26.11 was written off under bad debts.

From time to time we have found it necessary to suggest modifications of advertising copy and in every instance our suggestions have been favourably received. That a higher standard in medical advertising is being achieved is much in evidence. Any digression is usually traceable to the difficulties experienced by lay copy writers in writing upon medical subjects, rather than to intentional misrepresentation by the advertiser.

Your Managing Editor desires to acknowledge gratefully the cheerful and effective manner in which the Editors have cooperated in the exercise of all possible economies.

All of which is respectfully submitted.

F. S. PATCH,
Managing Editor.

Approved.

REPORT OF THE HONORARY TREASURER

Mr. Chairman and Members of the General Council:—

I have the honour to submit the report of the Honorary-Treasurer and the audited financial statements of Messrs. McDonald, Currie & Co., for the year 1936. As in previous years statements of the General Secretary's office, audited by Mr. J. H. Dignam have been incorporated.

I have pleasure in reporting that the deficit in 1936 is much less than that of 1935, the amount of it being $700.71. The fact of a deficit is rather disappointing. It was largely due to the fact that instead of the small profit on the Annual Meeting at Victoria, which was estimated, the expenditures for the meeting exceeded receipts by $1,082.87. There was too an extraordinary expense of $800.00 in connection with the emergency visit of Drs. Bazin and Routley to British Columbia early in the year.

Membership fees and subscriptions showed a gratifying increase, amounting to $1,079.26. Advertising receipts increased by $558.47. This was offset by an increase in Journal expenses of $1,370.51.

It has been the policy of the Association to spread its investments over the Dominion. Accordingly purchases of bonds of western provinces have been made. Recently we have been faced with a temporary loss on our investments in certain Province of Alberta bonds, due to facts which are well known. Not only has there been a marked reduction in the market value of the bonds but also in revenue, since we have refrained from cashing the coupons of the bonds. This action has been taken on the advice that has been secured, particularly from important investment bodies such as the Investment Dealers' Association of Canada, the Canadian Bankers' Association, and the Dominion Mortgage Association. It is hoped that the situation may be clarified in the near future, and in any event it is confidently expected that in the long run there will be no loss on the capital invested.

Certain changes have been made in the invested funds of the Association.

IN THE GENERAL FUND

$1,000.00 Province of New Brunswick, 4¾%, bought March 16, 1927, at $103.38, matured June 15, 1936; replaced by—

$1,000.00 Montreal Metropolitan Commission, 4½%, 1961, at $100.00.

BLACKADER LECTURE FUND

This Fund, inaugurated during the depression years, lacked $545.86 in subscriptions to bring the capital to $5,000.00. In 1936, the accrued revenue on hand being $1,014.20, Executive Committee decided to transfer from Revenue to Capital the amount required to bring it to the total originally intended. This transfer was made and the capital invested in—

$600.00 City of Drummondville, 4%, 1956, at $103.50.

All of which is respectfully submitted.

F. S. PATCH,
Honorary-Treasurer.

Approved.

AUDITOR'S REPORT

8th March, 1937.

DR. FRANK S. PATCH,
Honorary-Treasurer,
Canadian Medical Association,
3640 University Street, Montreal.

Dear Sir:—

We beg to report that we have completed an audit of the books and accounts of the Association for the year ended 31st December, 1936, and we attach the following:—

Statement No. 1.—Balance Sheet as at 31st December, 1936.
Statement No. 2.—Statement of Revenue and Expenditure for the year ended 31st December, 1936.
Schedule No. 1.—Schedule of Investments as at 31st December, 1936.
Schedule No. 2.—Schedule of Trusts and Trust Funds as at 31st December, 1936.
Schedule No. 3.—Schedule of Special Grants and Special Grant Funds as at 31st December, 1936.

The receipts and disbursements of the General Secretary in Toronto, as shown on a statement certified to by Mr. Dignam as Auditor, have been incorporated in the books.

We verified the cash on hand and in Bank and received confirmation of the securities which are held in safekeeping for Investment Account and for Trusts.

We found the books and accounts in excellent order and were given every assistance in the conduct of our audit.

Subject to the above remarks, we report that, in our opinion, the attached Balance Sheet is properly drawn up so as to exhibit a true and correct view of the state of the Association's affairs as at 31st December, 1936, according to the best of our information and the explanations given to us and as shown by the books.

Yours faithfully,
(Signed) McDONALD, CURRIE & Co.,
Chartered Accountants.

STATEMENT No. 1

BALANCE SHEET AS AT 31st DECEMBER, 1936

ASSETS		
Cash on Hand:		
Montreal	$ 25.00	
Cash in Bank:		
Montreal	$7,347.30	
Toronto:		
General Funds	4,925.21	
Annual Meeting	2,058.53	
	14,331.11	
		$14,356.11
ACCOUNTS RECEIVABLE:		
Advertising	$1,267.41	
Reprints	344.03	
Special Reprints	31.21	
Printing and Illustrations	968.01	
Sundries	85.48	
		2,696.14
INVESTMENTS:		
At Book Value, Schedule No. 1	$65,766.75	
Accrued Interest on Investments	419.40	
		66,186.15
Deferred Charges		146.55
Copies of History of Canadian Medical Association on Hand (at net cost)		768.10
Trust Funds as per Schedule No. 2		31,163.80
Special Grant Funds as per Schedule No. 3		5,006.15
Furniture and Fixtures—*Less* Depreciation		647.67
		$120,970.67

LIABILITIES		
Accounts Payable and Advertising Prepaid		$ 3,152.51
Prepaid Membership Fees, 1937	$7,562.00	
Prepaid Subscriptions, 1937	500.43	
		8,062.43
Trusts as per Schedule No. 2		31,163.80
Special Grants as per Schedule No. 3		5,006.15
SURPLUS ACCOUNT:		
Balance at Credit, 1st January, 1936	$73,973.89	
Add—Net Profit on Sale of Investments	312.60	
	$74,286.49	
Deduct—Excess Expenditure for Year as per Statement No. 2	700.71	
		73,585.78
		$120,970.67

Submitted subject to our report of this date.

(Signed) McDONALD, CURRIE & Co.,
Chartered Accountants.

Montreal, 8th March, 1937.

STATEMENT No. 2

STATEMENT OF REVENUE AND EXPENDITURE FOR YEAR ENDED 31st DECEMBER, 1936

REVENUE	
Membership Fees	$27,064.47
Subscriptions	3,160.46
Advertising	30,461.08
Special Reprints	1,753.60
Sundry Sales of Journal	234.27
Revenue from Investments and Bank Interest	2,555.34
Miscellaneous Revenue	2.50
Excess Expenditure for Year—Transferred to Surplus Account as per Balance Sheet	700.71
	$65,932.43

EXPENDITURE		
JOURNAL EXPENSES:		
Printing	$24,750.21	
Illustrations	879.20	
Agent's Commission	3,515.28	
Editorial Salaries	8,757.00	
Editorial Expenses	1,333.58	
		$39,235.27
ADMINISTRATION AND FINANCIAL EXPENSES:		
General Expenses	$ 502.83	
Travelling Expenses	6,692.79	
Office Expenses—General Secretary	373.70	
Postage	757.57	
Salaries—General Secretary	8,190.00	
Other	7,541.65	
Stationery and Printing	489.35	
Telephone and Telegrams	338.50	
Bad Debts	26.11	
Discount and Exchange	629.83	
Annual Meeting	1,082.87	
Depreciation of Furniture and Fixtures	71.96	
		26,697.16
		$65,932.43

SCHEDULE No. 1

SCHEDULE OF INVESTMENTS AS AT 31ST DECEMBER, 1936

GENERAL FUND

	Par Value	*Book Value*
City of Montreal 4½/46	$ 1,000.00	$ 975.00
City of Montreal 4½/47	2,000.00	1,856.20
City of Montreal 5/54	5,000.00	5,050.00
City of Montreal 6/44	500.00	542.50
Dominion of Canada 3/55	11,000.00	10,835.00
Dominion of Canada 3½/49	5,000.00	4,825.00
Dominion of Canada 5/43	100.00	98.25
Island of Montreal Metropolitan Commission 4½/62	8,000.00	8,220.00
Island of Montreal Metropolitan Commission 4½/61	1,000.00	1,000.00
Island of Montreal Metropolitan Commission 5/49	2,000.00	2,006.00
Jewish Hospital Campaign Committee Inc., of Montreal 5/46	5,000.00	4,950.00
Province of Alberta 4½/42	5,000.00	4,812.50
Province of British Columbia 4/57	5,000.00	4,775.00
Province of Ontario 4½/39	1,000.00	986.30
Province of Saskatchewan 4/54	1,000.00	900.00
Province of Saskatchewan 4½/60	3,000.00	2,835.00
Ritz-Carlton Hotel Co. 1st Mortgage 5/42	1,000.00	1,000.00
St.Henri Hospital Incorporated 4/48	1,000.00	1,010.00
St. Henri Hospital Incorporated 4/49	9,000.00	9,090.00
	$66,600.00	$65,766.75

Approximate Market Value, $66,035.75.

TRUST FUNDS

LISTER CLUB FUND:

City of Winnipeg 5/43	$4,000.00	$4,021.20
Province of Quebec 4½/63	1,000.00	985.00
	$5,000.00	$5,006.20

Approximate Market Value, $5,175.00.

OSLER MEMORIAL FUND:

Dominion of Canada 3/55	$2,000.00	$1,970.00
Dominion of Canada 3½/49	100.00	96.50
Pacific Great Eastern Railway 4½/42	500.00	497.65
Province of Alberta 4½/42	3,000.00	2,887.50
	$5,600.00	$5,451.65

Approximate Market Value, $4,807.87.

OSLER SCHOLARSHIP FUND:

City of Quebec R.C. Schools 5/55	$10,000.00	$10,003.00
Montreal Protestant Schools 5/52	2,000.00	1,995.60
	$12,000.00	$11,998.60

Approximate Market Value, $12,620.00.

BLACKADER LECTURE FUND:

City of Drummondville 4/56	$ 500.00	$ 517.50
City of Drummondville 4/62	100.00	103.50
Dominion of Canada 4½/46	200.00	195.00
Dominion of Canada 4½/57	200.00	204.00
Province of Alberta 4½/56	1,000.00	1,000.30
Three Rivers R.C. School 5½/44	3,000.00	3,030.00
	$5,000.00	$5,050.30

Approximate Market Value, $4,938.25.

SCHEDULE No. 2

SCHEDULE OF TRUSTS AND TRUST FUNDS AS AT 31ST DECEMBER, 1936

			Trust Funds	*Trusts*
LISTER CLUB FUND:				
Capital		$5,042.36		
Accumulated Revenue, 1st January, 1936	$963.35			
Revenue for Year	256.52			
	$1,219.87			
Deduct—Oration Expenses	500.65			
		719.22		
Represented by—				$ 5,761.58
Investments as per Schedule No. 1		$5,006.20		
Cash in Bank		739.18		
Account Receivable		16.20		
			$5,761.58	
OSLER MEMORIAL FUND:				
Capital, 1st January, 1936	$5,549.45			
Add—Profit on Sale of Investments	92.90			
	$5,642.35			
Deduct—Repayment to Revenue Account of Funds advanced in 1935 to complete purchase of investments	78.19			
		$5,564.16		
Accumulated Revenue, 1st January, 1936	$482.29			
Revenue for Year	140.17			
Reimbursement from Capital Account *re* Funds advanced in 1935 to complete purchase of investments	78.19			
		700.65		
Represented by—				6,264.81
Investments as per Schedule No. 1		$5,451.65		
Cash in Bank		813.16		
			6,264.81	
OSLER SCHOLARSHIP FUND:				
Capital		$12,108.90		
Accumulated Revenue, 1st January, 1936	$2,194.01			
Revenue for Year	627.68			
	$2,821.69			
Deduct—Scholarships Awarded 30th June, 1936	1,885.72			
		935.97		
Represented by—				13,044.87
Investments as per Schedule No. 1		$11,998.60		
Cash in Bank		1,046.27		
			13,044.87	
BLACKADER LECTURE FUND:				
Capital, 1st January, 1936	$4,454.14			
Add—Amount transferred from Revenue Account to increase Capital to $5,000.00	545.86			
		5,000.00		
Accumulated Revenue, 1st January, 1936	$793.05			
Revenue for Year	208.04			
	$1,001.09			
Deduct—Amount transferred to Capital Account	545.86			
		455.23		
Represented by—				5,455.23
Investments as per Schedule No. 1		$5,050.30		
Cash in Bank		404.93		
			5,455.23	
BLACKADER LIBRARY OF THE HOSPITAL SERVICE DEPARTMENT:				
Balance, 1st January, 1936		$316.14		
Donation Received during Year		50.00		
Bank Interest		5.69		
		$371.83		
Deduct—Expenditure—Books and Literature		61.94		
				309.89
Represented by—				
Cash in Bank			309.89	
CANADIAN RADIOLOGICAL SOCIETY LIBRARY FUND:				
Balance, 1st January, 1936		$343.73		
Bank Interets		3.70		
		$347.43		
Deduct—Expenditure for Books, etc		20.01		
Represented by—				327.42
Cash in Bank			327.42	
			$31,163.80	$31,163.80

SCHEDULE No. 3

SCHEDULE OF SPECIAL GRANTS AND SPECIAL GRANT FUNDS AS AT 31ST DECEMBER, 1936

			Special Grant Funds	*Special Grants*
DEPARTMENT OF HOSPITAL SERVICE:				
Balance at Credit, 1st January, 1936		$ 679.87		
Grant from Sun Life Assurance Co		11,000.00		
Bank Interest		14.16		
		$11,694.03		
Deduct—Salaries	$8,592.39			
Travelling Expenses	1,332.72			
Printing, Stationery, Literature and Office Supplies	352.73			
Postage	217.76			
General Expenses	183.42			
Depreciation of Equipment 10%	57.49			
		10,736.51		
Balance at Credit, 31st December, 1936				$ 957.52
Represented by—				
Cash in Bank		$440.13		
Furniture and Equipment—*Less* Depreciation		517.39		
			$ 957.52	
(Revenue, $11,014.16; Expenditure, $10,736.51; Excess Revenue for Year, $277.65.)				
DEPARTMENT OF PUBLICITY AND HEALTH EDUCATION:				
Balance at Credit, 1st January, 1936		$1,527.01		
Grant from Canadian Life Insurance Officers' Association		6,000.00		
Bank Interest		12.82		
Royalties on "What You Should Know" Series		123.30		
		$7,663.13		
Deduct—Salaries	$3,443.67			
Postage	373.15			
General Expenses	40.26			
Stationery, Printing and Literature	90.33			
Stereotypes	154.76			
Depreciation of Furniture and Equipment 10%	34.41			
		4,136.58		
Balance at Credit, 31st December, 1936				3,526.55
Represented by—				
Cash in Bank		$3,216.86		
Furniture and Equipment—*Less* Depreciation		309.69		
			3,526.55	
(Revenue, $6,136.12; Expenditure, $4,136.58; Excess Revenue for Year, $1,999.54.)				
POST-GRADUATE DEPARTMENT:				
Balance at Credit, 1st January, 1936		$580.08		
Deduct—Depreciation of Equipment 10%		58.00		
Balance at Credit, 31st December, 1936				522.08
Represented by—				
Equipment—*Less* Depreciation			522.08	
			$5,006.15	$5,006.15

Approved.

REPORT OF THE DEPARTMENT OF HOSPITAL SERVICE

Mr. Chairman and Members of the General Council:—

During the past year the services of this Department have again been fully utilized by our hospitals and their staffs. Numerous enquiries have been received relating to medico-hospital relationships, staff organization and improvement, nursing, administration, construction, finance, statistics, legislation and the many other aspects of hospital work. As far as possible these enquiries have been answered from our extensive reference library on hospital topics. In many instances, of course, enquiries necessitated the sending out of questionnaires. Several surveys have been made in various parts of Canada during the past year and a number of conferences were held. Quite a number of medical and hospital conventions have been attended, addresses given and articles prepared for publication.

Approval for Internship

The 1937 revision of the list of hospitals approved or recommended for internship has just been issued. This quite rigid grading now lists as "approved" 43 hospitals representing 674 internships; in addition there are 19 "recommended" hospitals with 59 internships. More hospital staffs are qualifying each year for this listing.

This office and the Advisory Committee have taken an active part in the preparation by a Joint Committee of the study on "Intern Education" which appears elsewhere in this report. There is a real need for such a comprehensive outline for the guidance of both staff men and interns.

Group Hospitalization

Plans providing hospitalization without charge to those contributing periodically to a central fund have met with increasing favour in many centres, and such plans have been carefully followed by this Department, particularly as the medical profession is very much interested in the relationship of these plans to medical practice. (See also Report of Committee on Group Hospitalization). It would now appear that the basic relationships being accepted as standard in these plans are proving not only acceptable but beneficial to the doctors. Quite a number of proposed plans have been submitted to this Department for study and criticism. The future of these plans would depend to a large extent upon the development of broader, more inclusive, voluntary plans, as proposed by the Ontario Medical Association, or of compulsory plans, as proposed in British Columbia.

The future relationship of the hospitals to possible health insurance plans has been given consideration. The effect of such plans upon the development, method of financing, control or staffing policy of public hospitals is of vital importance to the medical profession and their patients.

Construction

Hospital construction was so delayed during the depression years that there has resulted an unusual activity in construction during the past year. This Department has been freely consulted with respect to these building programs. Limited facilities prevent us giving as much assistance in this regard as we would like to furnish.

St. John's Convalescent Hospital

The new, well equipped St. John's Convalescent Hospital near Toronto opened by His Excellency the Governor-General last month has received considerable assistance from this Department, at an earlier stage, with respect to construction, and more recently in the setting up of its medical organization.

Radiologists and Hospitals

At the request of both the radiologists and the hospitals, this Department has taken part in conferences concerning this relationship. By a basis of agreement, unanimously accepted by representatives of both groups at a conference in Chicago in February, it is hoped that any existing difficulties can be gradually but surely cleared away.

Canadian Hospital Council

This organization, in which both hospital associations and the federal and provincial governments participate, has steadily grown since its organization in 1931. While it has been initiated and supported to a large extent by this Department, it is now able to finance most of its stenographic and printing expenses. Its study committees have been active in preparing reports on a wide range of subjects, and in formulating policies for hospital work and development and an active session is anticipated at its biennial meeting in the City of Ottawa on September 8th and 9th. The Council became incorporated during the past year.

The *Canadian Hospital* is now the official journal of the Canadian Hospital Council and, since the assumption of this direction a year ago, under the editorship of Mr. Leonard Shaw of Saskatoon, the quality and range of its contents has been very obviously improved. There has resulted increased responsibility for our office in connection therewith each month.

Again we desire to express our appreciation to the Sun Life Assurance Company of Canada, without the assistance of which body the work of this Department could not be maintained. This contribution towards the greater efficiency of our hospital provisions in Canada is much appreciated by these institutions and their medical staffs.

All of which is respectfully submitted.

G. HARVEY AGNEW,
Secretary.

Approved.

REPORT OF THE CENTRAL PROGRAM COMMITTEE

Mr. Chairman and Members of the General Council:—

The general order of the Scientific Program for the Annual Meeting is the same as that adopted last year for the meeting in Victoria. Last October your Chairman met the Local Program Committee in Ottawa and received from them a list of suggested subjects and speakers for the General Session and certain of the Sectional Meetings. Later your Committee received from the Local Program Committee and from Officers of Special Sections a list of subjects and speakers for other Sectional Meetings. From this general plan your Committee has drafted the Scientific Program for three General Sessions and meetings of eleven Sections. Every effort has been made to provide a balanced and instructive program.

Your Committee wishes to acknowledge the help and cooperation received from the Local Program Committee, Officers and Members of Sections, and the Secretary's Office in the preparation of the Scientific Program.

DUNCAN GRAHAM,
Chairman.

Approved.

REPORT OF THE COMMITTEE ON GROUP HOSPITALIZATION

Mr. Chairman and Members of the General Council:—

During the past year the number of group hospitalization plans operating in Canada has remained almost constant. None following approved methods has discontinued operation as far as we know; many have reported increase in membership. In several centres such as Moncton and Saint John plans have been under discussion for many months, and their early operation would seem probable. The Toronto Hospital Council has been giving favourable consideration to a group plan for over two years. This plan was about to be announced some months ago but was delayed pending the decision of the

Ontario Medical Services, Inc., to inaugurate a broader, more inclusive plan in the city of Toronto. If such plan to spread the cost of sickness be successful it was considered unnecessary to proceed with a plan for hospital care alone and thus confuse public opinion.

More rapid development has been noted in the United States than in Canada. The plans in Rochester, N.Y., Cleveland and Minneapolis are all over 60,000 in enrolment. The New York City plan has enrolled nearly 300,000 members already. The new Chicago plan is growing very rapidly. The plans in larger centres grow more rapidly because of the industrial nature of the community and the better publicity campaign possible with full-time directors. Hospital rates tend to be higher to the south, thus giving more incentive to join, and hospitals are more interested because of the usual lack of state or even municipal assistance for the care of non-pay patients. Another reason for slower adoption here is the greater imminence of health insurance legislation in several of the provinces.

The published report of this Committee has had wide distribution and is in constant demand. The Committee has no reason to make any changes in the recommendations set forth in this booklet.

Group hospitalization is of real interest and concern to our hospital staffs. It is most essential that we follow its progress closely and assist its proper development. Much better results can be obtained if we work with sponsoring bodies and help formulate basic policies rather than withdraw and suffer the consequences.

For these reasons we recommend that this Committee be continued.

All of which is respectfully submitted.

FRED. W. ROUTLEY,
Chairman.

Approved.

REPORT OF THE COMMITTEE ON LEGISLATION

Mr. Chairman and Members of the General Council:—

The Committee on Legislation hereby reports that it was not called upon to examine any question of legisation, either federal or provincial, since last meeting of the General Council.

All of which is respectfully submitted.

C. J. VENIOT,
Chairman.

Approved.

REPORT OF THE MEYERS MEMORIAL COMMITTEE

Mr. Chairman and Members of the General Council:—

No papers have been submitted this year for the Meyers Memorial Prize. Your Committee realizes that the restriction of the topic for discussion and the comparatively small number of practitioners who take an interest in this limited field, no doubt make it improbable that we shall ever have very many papers entered.

Your Committee would recommend that this matter be kept before the profession by means of notices and reminders published from time to time in the *Canadian Medical Association Journal*, and also by circulating to the Mental Hospitals of Canada information as to the conditions governing the prize.

All of which is respectfully submitted.

J. T. FOTHERINGHAM,
Chairman.

Approved.

REPORT OF THE OSLER MEMORIAL COMMITTEE

Mr. Chairman and Members of the General Council:—

A meeting was held on April 22, 1937, in the Osler Library, at which five members were present.

The Committee would again ask whether any suggestions from them about the choice of the Osler orator would be welcome or acceptable to the Executive Committee? If so, we should like to suggest for the next oration (1938) Dr. George Dock, 94 North Madison Ave., Pasadena, Cal., Dr. N. B. Gwyn, of Toronto, or Dr. C. D. Parfitt, formerly of Gravenhurst, now of Loomis, N.Y. These three are former assistants of Osler's and Dr. Gwyn was his nephew. Dr. Dock, though retired, is vigorous and much younger than his 76 years.

In considering the letter of the Hamilton Academy of Medicine of July 4, 1936, which was referred to us, it is regretted that the Academy is no longer able to carry on its good work for the memory of Osler, namely, the repetition of its most successful "Osler Day" of 1935, and, after this year, its annual provision for a local prize essay. Before making any suggestions it was resolved to get further information from local members of the Committee.

With regard to Osler Days elsewhere, we are planning to organize an annual gathering in Montreal in the Osler Library, preferably in March on or about the anniversary of his graduation; also it is suggested that during the next Montreal meeting of the Association a clinical session should be arranged at the Montreal General Hospital at which conditions Osler was specially interested in should be demonstrated. We also mean to approach friends of Osler with suggestions for similar meetings in Philadelphia, Baltimore, and possibly Toronto and Oxford.

Every medical student graduating in the United States since 1932 has been presented by Eli Lilly & Co., a chemical firm at Indianapolis, with a copy of Osler's "Æquanimitas and other addresses". I have been unable to persuade them to extend their generosity to students (about 475) graduating annually in Canada. We plan to approach some Canadian drug houses with the suggestion that one of them might imitate this good work.

It is interesting to note that an appeal has been launched in England for the church at Ewelme, near Oxford, which has to replace its beautiful 15th century roof, damaged by the death-watch beetle. The church includes the chapel of the Almshouse of which Osler was *ex-officio* master. It contains a fine memorial to him. In the literature sent out in connection with the appeal, we note the following sentence: "From 1904 to 1919, Ewelme Almshouse was fortunate enough to have the late Sir William Osler as Master. Of the many distinguished men who have held the position, none can ever have done so much for Ewelme and been so loved by its people as he."

Though the Association could not subscribe, it was thought that the Executive should be informed that friends of Osler would probably be approached individually for subscriptions.

All of which is respectfully submitted.

W. W. FRANCIS,
Chairman.

Approved.

REPORT OF THE DEPARTMENT OF PUBLICITY AND HEALTH EDUCATION

Mr. Chairman and Members of the General Council:—

During the past year, the Canadian Medical Association and the Canadian Life Insurance Officers' Association have provided health articles weekly to 345 newspapers and, in addition, special articles have been provided monthly to the Canadian National Railways Magazine.

In response to a questionnaire sent to the newspapers receiving the service, the following information has been noted:—

Number of papers who replied	165
Number who want the service continued	150
Number who were not particularly interested as to whether the service is continued	8
Number who do not want it continued	7

The general comments would indicate that the newspapers believe that the service is worth while and appreciated by the reading public.

For the nine month period ending May 15th, we have received and answered 775 letters of inquiry regarding health, from correspondents in various parts of Canada. In the main, the questions asked would indicate that the writers are sincere in their objective with respect to maintaining good health, and we believe we have been able to render service in our replies. In the preparation of the articles, we have had the kind cooperation of some of the leading authorities of the medical profession in Canada, and it is our opinion that the subject matter has been treated in an authoritative manner.

The writer would like to acknowledge with gratitude, the excellent cooperation which has been rendered by Mr. E. S. Macfarlane, Chairman of the Health Committee of the Canadian Life Insurance Officers' Association, in checking over articles and discussing the general conduct of the Department throughout the year.

All of which is respectfully submitted.

T. C. ROUTLEY,
General Secretary.

Approved.

In presenting this report, the General Secretary announced that a grant of $6,000 has been received from the Canadian Life Insurance Officers' Association for this Department for the year July 1, 1937 to June 30, 1938.

Council instructed that suitable acknowledgment for this tangible evidence of support be made to the Canadian Life Insurance Officers' Association.

REPORT OF THE COMMITTEE ON PHARMACY

Mr. Chairman and Members of the General Council:—

The Committee on Pharmacy of the Canadian Medical Association was instructed by Council to make a study of present legislation covering drugs and apparatus. Accordingly, your Committee has reviewed the federal legislation now in force, such as the Food and Drugs Act and the Regulations appertaining thereto, and the Proprietary or Patent Medicines Act.

FOOD AND DRUGS ACT

The linking of various interested professional bodies in an advisory capacity to the Government in the interpretation and operation of these Acts and Regulations would seem advisable. Accordingly, it is recommended that:—

1. In the administration of the Food and Drugs Act, the Department of Health should be advised by a Committee appointed by the Minister, but nominated by certain professional bodies such as the Canadian Medical Association, the Royal College of Physicians and Surgeons of Canada, the Dominion Council of Health, the Canadian Public Health Association, and the Canadian Pharmaceutical Association.

The *reasons* that have influenced this Committee in making this recommendation are:—

(a) The precedent offered by Great Britain in the Therapeutic Substances Act, 1925. This sets up a very strong and representative type of organization as shown by the following excerpts:—

4. (1) "For the purpose of framing regulations under this Act and for securing uniformity of standards, there shall be established a joint committee consisting of the Minister of Health, who shall be chairman, the Secretary for Scotland, and the Minister of Home Affairs for Northern Ireland:"

(2) "For the purpose of assisting the joint committee in the framing of regulations under this Act, there shall be appointed an advisory committee consisting of one member appointed by the Minister of Health, who shall be chairman, one member appointed by the Scottish Board of Health, one member appointed by the Minister of Home Affairs for Northern Ireland, one member appointed by the Medical Research Council, one member appointed by the General Medical Council, one member appointed by the British Medical Association, one member appointed by the Council of the Pharmaceutical Society of Great Britain, and one member appointed by the Council of the Institute of Chemistry of Great Britain and Ireland."

5. (1) The joint committee, after consultation with the advisory committee, may make regulations for the following purposes:—

(*a*) for prescribing the standard of strength, quality and purity of any therapeutic substance to which this Act applies:

(*b*) for prescribing the tests to be used for determining whether the standard prescribed as aforesaid has been attained:

(*c*) for prescribing unity of standardization:

(*d*) for adding to the Schedule to this Act any therapeutic substance the purity or potency of which cannot be adequately tested by chemical means:

(*e*) for prescribing the form of licenses under this Act and of applications therefor, and of notices to be given in connection therewith."

(b) The Department has appointed as advisors certain members of the profession mentioned above, but the Committee would point out that when giving advice these persons are not responsible in any way to their professions and are not compelled to consider the effect that their advice may have on the interests of the professions from which they are drawn or even the public health, but may consider solely the convenience of the Department of which they are paid members.

(c) The advice given to the Department by unpaid representatives of various professional bodies would carry more weight with Parliament than paid advisors.

(d) The Department of Health cannot contain within its organization men having adequate training and knowledge to decide all the intricate questions arising out of this Act, as evident from the appointment of paid advisors; nor can it properly view such matters from the broad professional basis as such nominated representatives could do.

It is also recommended that—

2. The powers of consideration of such an advisory committee should include any provisions of the Food and Drugs Act, and any of its regulations or revisions, but in particular part 1, paragraph 3 (*a*, *b*, *i*), paragraph 6 (*3a*, *b*) and paragraph 7 (*e*)

These read as follows:—

Part 1, Section 3.—The Governor in Council may make regulations (*a*) prescribing standards of quality for and fixing the limits of variabilities permissible in any article of food or drug the standard of which is not otherwise prescribed by this Act or the Meat and Canned Foods Act;

(*b*) requiring a label to be attached to any article of food or drug designed to prevent the public or the purchaser being deceived or misled as to the character, strength, quality or quantity of the article;

(*i*) adding to or removing from the list contained in Schedule A hereto such abnormal physical states, dis-

orders, diseases, or symptoms of diseases, and adding to or removing from Schedule B hereto such material, as may be deemed by the Minister to be necessary in the public interest.

Part 1, Section 6 (3).—Notwithstanding anything contained in sub-sections one and two of this section, the Governor in Council may make regulations respecting any or all of the drugs mentioned or described in Schedule B to this Act,

(*a*) prescribing standards of quality and potency;

(*b*) defining official methods for biological testing which methods shall permit manufacturers to have biological tests made in any laboratory.

Part 1, Section 7.—Food or drug shall be deemed to be misbranded within the meaning of this Act,

(*a*) if it is an imitation of, or substitute for, or resembles in a manner likely to deceive, another article of food or drug under the name of which it is sold or offered or exposed for sale and is not plainly and conspicuously labelled so as to indicate its true character;

(*b*) if it is stated to be the product of a place or a country of which it is not truly a product;

(*c*) if it is sold or offered for sale by a name which belongs to another article;

(*d*) if it is so coloured or coated, powdered or polished that damage is concealed, or if it is made to appear better or of greater value than it really is;

(*e*) if false or exaggerated claims are made for it upon the label or otherwise.

PATENT OR PROPRIETARY MEDICINE ACT

With respect to the Patent or Proprietary Medicine Act, it is recommended that:—

3. A similar or the same Committee be empowered to act in an advisory capacity with respect to the provisions, regulations and revisions of the Patent or Proprietary Medicine Act.

It is further recommended that:—

4. Such Committee or Committees shall make, from time to time, those recommendations to the Department which are considered advisable by the Committee or Committees.

PHYSICAL THERAPY APPARATUS

In view of the increasing use of electro-diagnostic, electrotherapeutic and other physical therapy apparatus by physicians, hospitals, drugless practitioners and by the general public and the observation that certain equipment sold would appear to be of doubtful diagnostic or therapeutic value, it is recommended that:—

5. This Committee or another to be named should be empowered to cooperate with the Government of Canada and with other interested organizations or bodies in the preparation of legislation which would elaborate suitable standards and regulations covering or defining the asserted or claimed potency and uses of such apparatus and which would protect the public and those interested in using such equipment from misrepresentation, fraud or unsuspected dangers in operation.

All of which is respectfully submitted.

V. E. HENDERSON,
Chairman.

Approved.

After discussion of this report, the Committee on Pharmacy was instructed to appoint a subcommittee to give careful consideration to diagnostic appliances. Arrangements were made for the presentation of this report to the Governmental authorities.

REPORT OF THE COMMITTEE ON ECONOMICS

Mr. Chairman and Members of the General Council:—

1. COST OF PRACTICE

At the meeting of the Council in Victoria a year ago the then Committee on Economics recommended that the incoming Committee give consideration to evolving a plan to obtain figures on the cost of medical practice. Your Committee is fully aware of the difficulties inherent in any attempt to obtain figures of this nature; figures that are really accurate and of value from an actuarial standpoint and so it was with no great expectation that it endeavoured throughout the first part of the year to obtain cooperation from the various Provinces.

A report was received only from the Province of British Columbia.

As a result of its own struggle in the field of Health Insurance that Province sent out a comprehensive questionnaire to over 600 practitioners. In all 357 replies that were considered satisfactory were returned and the answers analyzed. The answers applied to gross and net incomes for the years 1929, 1933 and 1935. Returns were filed by 243 general practitioners, 40 part time specialists and 74 full specialists and the percentage of returns was fairly evenly distributed throughout the Province.

The average cost of practice for the 357 physicians making returns was:—

1929	36.6%
1933	41.7%
1935	37.4%

The cost figures, according to the type of practice engaged in, were:—

	1929	*1933*	*1935*
General Practitioner	34.5	40.6	37.0
Part Specialist	41.2	42.7	38.3
Full Specialist	38.3	43.9	37.9

It appears to your Committee that these figures obtained from over 50 per cent of the medical men and from a group scattered fairly uniformly over the Province are as accurate as are likely to be obtained at the present time by the questionnaire method. They are figures closely in line with the accepted figure of 40 per cent and they indicate that, as would be expected, costs are proportionately greater in bad years.

2. PRINCIPLES OF HEALTH INSURANCE

At the same meeting of the Council in Victoria the following resolution was passed:—

"That the Committee on Economics be instructed to study, clarify and amplify the Principles of Health Insurance as laid down in the report of the Committee on Economics and approved at the meeting in Calgary in 1934."

Your Committee felt that every effort should be made to obtain from the various Provincial Executives, their Committees on Economics, or both, their studied conclusions as to any way in which they considered the above Principles could be clarified, amplified or changed. Again we met with partial failure. Replies were received only from Ontario, British Columbia, Manitoba.

From the reports received from these Provinces, however, and from its own deliberations, your Committee begs to recommend to Council the following alterations in the wording and intent of the Principles as laid down in the report of the Committee on Economics at the Calgary meeting in 1934:—

At the outset your Committee wishes to re-affirm the opinion that we favour the appointment of a Royal Commission to fully explore the question of a Federal Scheme for Health Insurance.

RECOMMENDATIONS OF PRESENT COMMITTEE ON ECONOMICS

1. That in the Provinces where Health Insurance is established it be administered under an independent Health Insurance Commission and that there should be close co-operation between this Commission and the Provincial Department of Public Health with a view to making full use of preventive services.

2. That a Central Health Insurance Board and Local Insurance Boards be appointed, representative of all interested to advise the responsible administrative authority.

3. That the professional side of Health Insurance Medical Service be the responsibility of the organized medical profession through the appointment of a Central Medical Services Committee and Local Medical Services Committees to consider and advise on all questions affecting the administration of the Medical benefit.

4. That the question of the establishment of local areas for health insurance administration be left to the decision of the individual Provinces.

5. That the whole Province be served by adequate Departments of Public Health, organized on the basis of provision of individual health supervision by the health insurance general practitioner.

6. That there be a Health Insurance Fund and that "Regional Officers," to act as supervisors and referees be appointed, paid and controlled by the Central Board or Commission .

7. That medical care for indigents be provided under the Plan, the Government to pay the premiums of the indigent, who then receive medical care under exactly the same conditions as the insured person.

8. That the Plan be compulsory for persons having an annual income below a level which upon investigation by competent local authorities proves to be insufficient to meet the costs of adequate medical care.

9. That the dependents of insured persons be eligible for the medical benefit.

10. That there be offered, on a voluntary basis, to those with incomes above the Health Insurance level Hospital care Insurance, and that this be administered as part of the Health Insurance Plan, such hospital care not to include medical service other than hospitalization.

11. That the only benefit under the Plan be the medical benefit.

12. That the medical benefit be organized as follows:—

(*a*) Every qualified licensed medical practitioner to be eligible to practise under the Plan.

(*b*) The insured person to have freedom of choice of medical practitioner and vice versa.

(*c*) The medical service to be based upon making available to all a general practitioner service for health supervision and the treatment of disease.

(*d*) Additional services to be secured *ordinarily* through the medical practitioner.

(1) (*a*) Specialist medical service.
(*b*) Consultant medical service.
(2) Visiting-nurse service (in the home).
(3) Hospital care.
(4) Auxiliary services—usually in hospital.
(5) Pharmaceutical service.

(e) Dental service, arranged direct with dentist or upon reference.

13. That the Insurance Fund should receive contributions from the insured, the employer of the insured and the Government.

(*a*) Payment of the premium of the insured, in certain proportions to be determined, should be made by the employee, employer and Government.

(*b*) Where an insured person has not an employer or where it is not practical for the Government to collect from the employer the Government should pay in for that insured person what would be the employer's share as well as its own share of the premium.

(*c*) Where the insured is "indigent" or has been out of work long enough to come without the scope of the provisions of the Act as relating to an insured employee the Government should assume payment of the full premium.

14. That the medical practitioners of each province be remunerated according to the method or methods of payment which they select.

15. (*a*) That the Schedule of Fees in any Health Insurance Scheme shall be the Schedule of Fees accepted by the organized profession in the province concerned.

(*b*) That all Schedules of Fees be under complete control of the organized medical profession in each Province.

16. That the contract-salary service be limited to areas with a population insufficient to maintain a general practitioner in the area without additional support from the Insurance Fund.

17. That no economic barrier be imposed between doctor and patient.

18. That the volume of work demanded from and the remuneration to members of the various professions be such as to assure a standard of service equal to or better than present-day standards.

At the time negotiations were under way between the Health Insurance Commission and the Health Insurance Committee of the College of Physicians and Surgeons of British Columbia the Commission announced that it proposed to bring in a list of "Exclusions" *i.e.*, a list of diseases and conditions for which, when present amongst members of the insured group at the time of the commencement of the working of the Health Insurance Act, it would not be responsible as far as treatment and hospitalization were concerned,—"for the first year at least."

The Commission invited the co-operation of the Health Insurance Committee in drawing up this list and this the Committee agreed to and did but it announced at the commencement that the purpose of any Health Insurance Scheme should be improvement of the health of the insured, and, therefore, in principle it was opposed to any exclusions.

Your Committee is in agreement with this and invites discussion of Council on the question of "exclusions" under any Health Insurance Scheme.

3. MEDICAL ECONOMICS AND HEALTH INSURANCE

From the standpoint of medical economics the twelve months that have passed since this Council last met have been momentous ones for the profession in Canada.

All across the Continent it has been apparent that the nature and character of the practice of medicine, in as far as its relation to the State and the Public is concerned, is continuing to alter and it is furthermore apparent that this change is inevitable and will continue to work for some time to come. Opinion in the profession may be divided as to the efficacy of these changes in so far as they affect the Public and the practice of medicine; nevertheless, we should one and all realize that we must be ready to meet these changes and be ready to direct them into channels that cannot do otherwise than lead to a proper protection of the interests and health of the people and a proper protection of the standards of the practice of medicine and the legitimate interests of the medical profession.

Your Committee, therefore, takes this opportunity of congratulating the Executive Committee on the forward step it has taken in appointing Doctor T. C. Routley to be in charge of the Bureau of Economics of the Canadian Medical Association. It is a task for a full-time man whose heart is in the work and your Committee is of the opinion that Doctor Routley is peculiarly fitted and amply endowed with all that which is necessary to make the Bureau a success.

As a result of co-operation between the Provinces named and your Committee the following reports on present local medical economic problems have been obtained for the information of Council.

ALBERTA

HEALTH INSURANCE

The present situation in the Province of Alberta of Health Insurance has reached the stage of hopeful expectancy.

The Bill for Health Insurance passed in the dying days of the U.F.A. Government unacted upon, and the provisions of the Bill to form one or more "test units" has not been implemented in any way.

The Bill itself was an attempt to cover the whole field of health insurance, medical and dental services, hospitalization, drugs and dressings as well as limited nursing services, therapeutic and remedial measures as well as supplying all necessary surgical appliances.

Unlike Compensation Acts, there were no provisions for benefits in kind or compensation payments. It was not proposed to do away with the Workmen's Compensation Board, or to interfere in any way with personal insurance or benevolent societies; but it was expected that the Health Insurance Scheme, would be so comprehensive that such societies would no longer be needed.

The basis upon which the economics of the Health Insurance Scheme was worked out leaves much to be desired, in that there was not a definite actuarial survey made. Information was gathered from different Government Departments from data obtained from local units and a general survey of work done in other countries, none of which was similar to what was proposed. It was therefore, clear the plan was one of "trial and error" actual facts being unobtainable.

No agreement was reached as to what would be the remuneration paid to the parties rendering services, but from a medical viewpoint it was felt that the fees might approximate fifty per cent of normal fees, or somewhat like the Workmen's Compensation Board fees.

Some of the weak points of the Plan are lack of actuarial data, area of distribution of medical services necessary, lack of conveniently situated hospitals, transportation difficulties, provision for reference cases (the word adequate medical services may mean so much or so little) being on a contributary basis collection of fees from non-property holders would be difficult, and transients would offer another problem of some magnitude. It was fully realized that many difficulties would be encountered on account of the limited scope of the Act; but it was felt much might be learned from the experiment.

The attitude of the profession was that of willingness to try any scheme which safeguarded certain definite principles, *viz.*, freedom of choice of doctor, recognition of the necessity of preventive medicine, payment for services rendered, preservation of professional secrecy and non-regimentation of medical men other than the governance under the statutes of the Province. It was definitely established that the medical profession would resent the imposition of "State Medicine" in other than usual activities of a Department of Health as presently constituted.

It was estimated that the cost would be $14.50 *per capita*, 2/9 of which would come from the Government treasury, 7/9 was to come from the unit, to be collected by the municipalities from the income receivers. Employers were to collect 5/9 from the employees and pay 2/9 themselves on account of the employees. If a farmer had two sons sharing in the proceeds of the farm, he would be responsible for sending in three times 7/9 of $14.50 for each one including himself or practically $100.00. This was based on a calculation that there was one income receiver for every three of the population and each income receiver had to pay for three persons at $14.50 *per capita* less the 2/9 borne by the Government. The unit was to contain 20,000 persons, and the people had to carry the scheme by vote. It could not be applied to homestead areas or dried out areas so would never be universal. If successful in the test units others were to be established later on.

MEDICAL ECONOMICS

The greatest problem would seem to be collection for services rendered and the problem for medical care of indigents. Our debtors have entrenched themselves owing to Provincial legislation, thus making forced collections almost impossible. The farmer can, and does usually, delay payment of medical accounts, until other demands are satisfied. By law, certain debts are preferred but not medical accounts. The Statutes place the responsibility on the municipality for the care of the resident indigents, but few municipalities assume it, and no one but the indigent can take action against the municipality and he has not the means or the time to do it. What constitutes an indigent is a cause for dispute, regardless of the definition of the Act.

The Provincial budget for 1936 for medical care and hospitalization of the indigents in local improvement districts was $185,000, half of which went to the hospitals; a survey of the municipalities showed that they paid about $180,000 for medical care of indigents, totalling about $270,000 for the Province. On the basis of $4.20 per year or 35 cents per month for those on relief, 90,000, it would take $378,000 per year to do as is being done in Ontario.

Some municipalities alone and others in combination have made contracts with medical men, at varying rates according to the services to be rendered from $200 to $5,500 per year, while in other districts the people have group insurance at a rate of $25 per year per family.

It can be stated that no systematic plan for the whole Province has been evolved; local conditions have very largely controlled the form of contract adopted.

We submitted a Plan similar to that in Ontario but so far the Government has not seen fit to adopt it. This would care for the needy and would gather valuable data in a way the unit plan of the late Government would not, as it was to be tried in districts only where the income earners would be able to meet the money required, roughly $225,000 per unit.

(Signed) GEO. R. JOHNSON.

MANITOBA

Relatively few have given serious thought to Health Insurance, as it has not been with us a live issue as in British Columbia. In discussions it is frequently dismissed as state medicine and therefore deleterious to the profession. Also the question arises to a certain extent in Winnipeg, how far would health insurance interfere with the supply of clinical material for teaching purposes in the hospitals utilized by the Medical College.

There is neither antagonism to nor enthusiasm for the principles laid down in the Calgary report. Income level might become a very live issue. I think that a complete medical service and free choice of doctor are in general approved. Cash benefits are regarded as outside the scope of the profession. In answer to question two, an attempt was made to start trial insurance in two rural areas but failed for financial reasons. Municipal doctors seem to be growing more popular with the municipalities, though the number at present is only six.

The Greater Winnipeg Medical Relief Scheme has entered on its fourth year. It is popular with the unemployed, for they get an excellent service. The doctors have co-operated loyally. Of course, there are difficulties mainly financial, but the scale of fees paid is very much higher than we find in Toronto or Montreal, and good records are being kept.

The relations between the Department of Health and the profession are probably happier than in most Provinces in Canada. The Deputy Minister of Health is also Secretary of the Manitoba Medical Association, and his services as liaison officer have been very valuable. The Minister of Health, who is not a doctor, has breadth of vision, a sincere desire to improve conditions, and is always willing to listen sympathetically to the problems presented to him. I quote from the daily press some of his views expressed in the legislative chamber recently. "The minister touched on the debated topic of health insurance without committing himself definitely one way or the other. No scheme will be started in Manitoba,

he says, without consent and promised co-operation of the doctors."

(Signed) E. S. MOORHEAD.

ONTARIO

A number of items concerning medical economics in the Province of Ontario are of interest to the profession throughout Canada. Important in the light of the situation in British Columbia are some of the statistics relative to Ontario Medical Relief Administration by the O.M.A. This service provides for home and office visits and confinements, but no allowance is made for surgery, specialists or any service in hospital.

"If there is any moral in our experience it is this: where the state sees a gap in medical service, it will fill it even if the profession rails against it. It is for us to offer our advice as to how it shall be filled, otherwise we may lose the chance of placing ourselves in a position of intimate consultation and co-operation. Even though one believes state activity to be impetuous, it is well to be in a position of consultation in order that the point of view of the medical profession shall be placed actively, if not loudly, and persistently before those in authority."

The profession in Ontario is pleased that the General Secretary is now overseas making a first-hand study of state health services in Great Britain and on the Continent.

(Signed) W. S. CALDWELL.

ONTARIO MEDICAL RELIEF STATISTICS

	Old Ontario	*New Ontario*	*Province 1937*	*Province 1936*	*Increase or Decrease*
Total on Relief (sum of 12 months).....	3,161,992	775,739	3,937,731	4,610,400	-17.08%
Total number of patients.....	485,645	80,249	565,894	589,037	-3.93%
Morbidity Rate.....	15.35%	10.34%	14.37%	12.78%	+12.5%
Average gross cost per patient per month.	3.99	4.33	4.04	4.47	-9.61%
Proportion of doctors' gross accounts paid.	32.93%	69.85%	38.54%	45.22%	factors altered

From the above, we observe that, as is the tendency in all public medical service schemes, morbidity rates have increased. In the light of this, it is interesting to note that the cost per patient is down over 9%. Of the 25c per month per person on relief received from the Provincial Government, 16% was set aside for drugs. The doctors (in old Ontario) received 32.93% of their gross accounts (after having been "taxed"—*i.e.*, discounted to meet requirements of the regulations and of average service—by fellow practitioners). It can thus be deduced that the *per capita* amount per year required to pay normal fees for this limited service is $7.65. This figure, determined by actual experience in a limited service, contrasts sharply with the maximum offered the profession of British Columbia for a complete service.

An arrangement has been effected with the Provincial Government whereby the *per capita* allowance is to be increased from 25c to 35c as from March 1, 1937, 6c of which is to be apportioned for drugs. It is estimated that on an average the doctors will receive therefrom almost 50% of normal fees and a small additional *pro rata* allowance for drugs when these are dispensed by the doctor.

One development during the year is thought to be of momentous significance. After a year of continuous negotiations, organized medicine in Ontario is sponsoring a scheme of prepayment for medical services ("health insurance") on a voluntary, non-profit basis. Administration is in the hands of two incorporated companies the Directors of which include both medical and non-medical personnel in almost equal proportion. Complete medical service to salaried workers and others, including their dependents, is being planned. Any doctor may participate and patients have free choice of physician. One unit will offer facilities to persons of any income while the other sets an income maximum of eighteen hundred dollars. In each case the doctors have full jurisdiction over the administration of the medical services and all fees will be paid on a unit-of-service basis. Following this experiment, it is hoped that from the statistics on the cost of medical care which will be obtained and from the experience with the principles of health insurance which will be tried out, the profession may be able to make a worth-while contribution to the solution of the problem of state health insurance.

The vast majority of the profession in Ontario now recognize the inevitability of state health insurance. This was shown by the answers to a questionnaire submitted by the O.M.A. a little over a year ago and by which the profession declared themselves overwhelmingly favourable to the general principle. As a result, the O.M.A. now accepts the advice of Dr. Charles Hill, Deputy Medical Secretary of the British Medical Association who in addressing an audience of Toronto doctors said:

4. HEALTH INSURANCE IN BRITISH COLUMBIA

In as much as Health Insurance went through an acute phase in British Columbia during the past year it is considered that it would be of interest and of value to Council if the history of the Health Insurance movement in that Province was reviewed in some detail.

In the year 1919 the Government of that Province appointed a select committee to "inquire as to laws relating to the subject of Mothers' Pensions, Maternity Insurance, Health Insurance and Public Health Nursing which are in force in other countries; to collect facts as to the actual operations of those laws and as to how far they are found satisfactory; to inquire as to whether and to what extent the public interest requires the introduction of such laws in to the Province of British Columbia and generally to enquire into all matters affecting the said subjects respectively."

No report of this Committee was ever printed except that part dealing with Mothers' Pensions.

The next definite step was in the year 1929, when a Royal Commission was appointed to "inquire into all matters affecting Maternity Benefits and Health Insurance." In 1932 this Commission transmitted its final report to the Government with the recommendation of "the early establishment in British Columbia of a suitable compulsory Health Insurance Plan including Maternity Benefits." Nothing further was done until the year 1935 when there issued from the office of the Provincial Secretary the draft of a Plan of Health Insurance. This draft bill was sent broadcast throughout the Province and the public was asked to study it. There then foollwed the setting up of Public Hearings Committee, before which many interested parties and public bodies, including the medical profession, appeared and submitted briefs.

Into the question of how much or how little the Profession in British Columbia was consulted in the drawing up of that draft bill it is unnecessary to enter. Suffice it to say that it was entirely unaware of the provisions of that draft bill until it was published and became public property. That original draft bill had in it much that would have gone towards the making of a sound Act and it included the indigent. The Health Insurance Committee of the College of Physicians and Surgeons in its brief submitted to the Hearings Committee pointed out the advisability of waiting for the findings of a Federal Royal Commission on this subject and then proceeded, as it felt it had the right to do, to strongly criticize and object to some of the details.

In November, 1935, the report of the Hearings Committee was published and amongst its recommendations was the following one:—"The Health Insurance Commission should be empowered to make satisfactory provision for the medical care of non-contributory persons (indigents) and financial responsibility for this service

should be entirely assumed by the Provincial Government."

No further information was made available to the medical profession and in the Spring of 1936 the Legislature met and a radically altered Health Insurance Act was presented to the Government Caucus;—again an Act in the framing of which the profession in British Columbia had not been consulted. In this Act, amongst other retrograde steps, the indigent and many classes of low wage earners were excluded and the Scheme was to be entirely self-supporting from the monies collected from the insured and their employers—it was to be Health Insurance for those who could pay.

While the House was in Session and before the bill was introduced into the Legislature, the Health Insurance Committee, accompanied by Drs. Bazin and Routley, met the Cabinet and protested the exclusion of the indigent and the rate of remuneration set for the medical profession. Despite these protests, and in face of strong opposition, the bill passed its third reading on March 31st, 1936, and awaited only the Proclamation of the Lieutenant-Governor to come into operation.

In the early Summer of 1936, the first part of the Act was proclaimed and the members of the Health Insurance Commission were appointed. With this Commission the Health Insurance Committee of the College then entered upon a protracted series of negotiations. From the outset it was fully realized that while the Commission had wide powers it could in no way alter the Act; nevertheless, the Health Insurance Committee, at the very commencement of the negotiations, clearly stated, not only to the Government but to the Commission, that the solution of the problem of the medical care of the indigent must be intimately linked up with the bringing into force of any Health Insurance Scheme in British Columbia. During the ensuing months, the Committee returned again and again to this point, urging the Government to state its policy with regard to the indigent. The final word in January, 1937, was that after Health Insurance got under way the Government would see what could be done about the indigent.

In the late Summer of 1936, the Commission submitted to the Committee for discussion a scheme for providing for and paying for the medical services to the insured. It is unnecessary for your Committee to go into the details of that scheme—an analysis and criticisms of it appeared in the *Canadian Medical Association Journal* for March of this year. Suffice it to say that a study of the Scheme proved it to be entirely unsatisfactory, not only as to the methods of providing service and paying the medical profession, but also as to the amount of remuneration offered, and the Commission was promising and undertaking to sell to the insured hospitalization which the Health Insurance Committee was convinced the Commission could not supply. It is common knowledge to the ordinary man on the street that the hospital situation in the larger centres of population in British Columbia is impossible at the present time. Overcrowding in the hospitals has brought about an acute situation that is crying for solution at the present time and, under the circumstances, to promise hospitalization to a large insured population was promising something that the Committee was satisfied the Commission could not carry out. Further discussions failed to alter the decisions of the Commission, except in the matter of some details, except that it finally increased the amount of remuneration offered from $5.00 to the still far from adequate sum of $5.50.

On January 20th was held the final meeting between the Commission and the Committee, whose numbers for that meeting were augmented by representative medical men throughout the Province. At that meeting the Commission stated that the time for bargaining was now at an end. It asked the profession to try its scheme for a year and, if at the end of that time the scheme proved unsatisfactory, it would, in consultation with the profession, try to make it satisfactory. If the amount of remuneration proved inadequate it would recommend to the Government that the levies be raised, services reduced, a subvention be granted by the Government to the Health Insurance Commission or some combination of the above policies be carried out. Finally, it asked for a speedy decision by the medical profession as collections were to start on March 1st, with the Act going into operation on April 1st. The Committee reiterated its objections, stated it would now lay the Scheme of the Commission before the profession, would not recommend it and conduct a Province-wide ballot to obtain the answer of the profession. It asked also that in the meantime the Commission supply all medical men with a copy of the Scheme. This was done; mass meetings of the profession were then promptly held at Victoria and Vancouver and the Scheme was overwhelmingly rejected. The subsequent ballot conducted by the College of Physicians and Surgeons showed a vote of 622 against and 13 for the Scheme. In the early days of February, following the mass meetings, the profession, through its Committee, stated its position in the press and over a Province-wide radio broadcast and it obtained strong support, not only from the press, but from a large section of the public. On February 19th, Premier Pattullo postponed the Health Insurance Act *sine die*.

The subsequent history of Health Insurance to the end of April, the time this report was prepared, is soon told. Early in that month the Government announced that a general election would be held on June 1st, and in a manifesto on Health Insurance, published over the signature of the Premier, the electors were informed that a Plebiscite on Health Insurance would be held. The electors were asked to vote "yes" or "no" to the question:

"Are you in favour of a comprehensive Health Insurance Plan progressively applied?"

The people were also informed that—"Those who may come within the scope of a Health Insurance measure must necessarily be those who make contributions thereto. The care and treatment of those unable to make any contribution is a separate question."

All of which is respectfully submitted.

WALLACE WILSON,
Chairman.

Approved.

HEALTH INSURANCE IN EUROPE

The General Secretary gave a verbal report touching upon his study of health insurance and allied problems in England, Scotland, Belgium, Denmark, Germany and France. A full report covering this study will be available in the near future.

REPORT OF THE STUDY COMMITTEE ON CANCER

Mr. Chairman and Members of the General Council:—

This report in a broad sense is a record of the progress of the Cancer Study Committee of the Canadian Medical Association, from the date of its inception in November, 1931, until May 1st, 1937. From year to year its personnel has changed. Its activities have been continuous: they cannot be divided into watertight compartments limited by the arbitrary dates of the calendar.

When the present Chairman took office in late July, 1936, he was provided by the General Secretary with the names of the members of his Committee. Each one was listed as being the Chairman of the Cancer Committee of his province and as the official appointee of his Provincial Association or Division. The Committee therefore represented not merely the members of the Canadian Medical Association but the whole of organized medicine in Canada. The Chairman was empowered to select a Nucleus Committee to assist him. I now desire to publicly and gratefully acknowledge the invaluable assistance given by that group of Calgary doctors.

The instructions to the Committee were contained in a folio marked, "The Complete Story Regarding Cancer as Extracted from the Minutes of the Executive Com-

mittee and Council from 1933 Up to the Present" (October, 1936). The Nucleus Committee studied the instructions. In Saint John in June, 1933, Council had instructed Executive to carry out the recommendations embodied in a report which it had accepted.

These instructions in essence were:

(*a*) To take steps to organize a National Medico-Lay Society to aid in control of cancer. Its chief functions would be to provide facilities to carry on education of the lay public and to collect money necessary for education of doctors and lay public in regard to cancer.

(*b*) To organize within the Canadian Medical Association itself a department which would carry on cancer education among doctors and provide the National Medico-Lay Society with such medical information and instruction as it might require.

With a view to submitting a detailed plan under which these instructions might be carried into effect the Nucleus Committee prepared a memorandum: a copy was mailed to each member of the Committee. It contained proposals which each was asked to discuss.

As replies were received, they were multigraphed and mailed to each member; so that each one had in his file the opinions of all of the others. When all replies were received they were attached to the original memorandum and marked "Exhibit A".

The Nucleus Committee analyzed this. As a result it prepared two documents. One dealt with activities which the Canadian Medical Association should establish either with or without external financial aid. It was marked "Exhibit B".

A second was a brief to be presented by the Chairman of this Committee on behalf of the Canadian Medical Association to the Board of Trustees of the "King George V Silver Jubilee Cancer Fund for Canada". This contained a request that the Board of Trustees accept the responsibility for causing to be set up a National Society for the Control of Cancer. Its structure was described in some detail. This brief was marked "Exhibit C".

These three documents were submitted to Executive in Session in Ottawa in October, 1936, as an interim report. The minutes of Executive Meeting which are attached contain the further instructions to the Chairman of this Committee.

The Chairman attended the meeting of the Board of Trustees of the "King George V Silver Jubilee Cancer Fund for Canada", on February 22nd, 1937. He presented the brief. The Board firmly declined to accept any responsibility for establishing a National Society. They agreed to adjourn until the following day in order to give your representative time to prepare a further communication which would be supplementary to the brief already submitted.

This supplementary communication marked "Exhibit D" was prepared. It contained a request for money and an offer on the part of the Canadian Medical Association which was made contingent upon the endorsation of the Executive of the Canadian Medical Association.

The whole proposal was then discussed by the Trustees. As a result they offered the Canadian Medical Association a grant of fourteen thousand dollars annually. The minutes of the meeting of the Board of Trustees contains a confirmation of this grant: a copy is submitted. The Chairman of the Cancer Study Committee presented a further interim report to the Chairman of Executive on February 26th, 1937.

Copies of the folio containing the original instructions, the various documents marked Exhibits A, B, C, and D, the minutes of the Executive Meeting, October, 1936, and the minutes of the meeting of the Board of Trustees of the "King George V Silver Jubilee Cancer Fund for Canada", February 22nd, 1937, are attached. They form a part of this report and are inseparable from it. Exhibit A contains only a summary of the replies as submitted in the interim report to Executive. The original replies are filed with the General Secretary.

In conclusion I desire to acknowledge the value of the work done under the Chairmanship of Dr. Alexander Primrose. He and those members of his Committee who loyally supported him prepared a ground work without which whatever success has attended the efforts of the present Committee would have been impossible.

All of which is respectfully submitted.

J. S. McEACHERN,
Chairman.

EXCERPT TAKEN FROM COMMUNICATION FROM THE SECRETARY OF THE "KING GEORGE V SILVER JUBILEE CANCER FUND FOR CANADA" DATED MARCH 24, 1937

MINUTES OF THE 3RD MEETING OF THE TRUSTEES OF THE "KING GEORGE V SILVER JUBILEE CANCER FUND FOR CANADA" HELD IN THE LIBRARY OF THE SUPREME COURT OF CANADA AT 5.00 P.M. FEBRUARY 22, 1937

"Dr. McEachern was then asked by the Chairman to present the suggestions formulated by his Committee of the Canadian Medical Association. He had been instructed by the Executive of his Association to present a motion passed at the annual meeting in Victoria in June, 1936, which read as follows:—

'That the Board of Trustees of the King George V Silver Jubilee Cancer Fund for Canada be asked for an annual grant, for a period of five years of between twelve and fifteen thousand dollars as the Study Committee on Cancer may determine for a program of education of the public and the medical profession including secretarial services.' "

Upon instructions of the Chairman, the above motion was to be incorporated in the Minutes.

Dr. McEachern then presented a brief in three portions, and made a formal request as follows:—

"I would like the Board of Trustees of the King George V Silver Jubilee Cancer Fund for Canada to assist the Canadian Medical Association with a grant of at least $14,000 annually to carry out the education of the medical men and the public.

Considering our present status in Canada, I am quite convinced that the education of the medical profession and the public is the most urgent need and the one promising the most immediate helpful results. The plan we suggest of carrying out the education of the medical profession, improving the cancer work in hospitals, and collecting very important clinical statistics which might be assembled and studied, has been given much thought by our Executive and approved as the most efficient. It also very materially stimulates clinical research in the field of cancer.

The factor of educating the public is just as important a need as that of the medical profession. They should go on side by side. The organization of the two in the same community is practically inseparable. The Canadian Medical Association desires to organize a lay and medical co-operative group which would undertake the education of the public and be the means of raising additional funds for combating the ravages of cancer among the people of Canada."

After very careful deliberation by the Trustees, it was moved by Mr. King and seconded by Mr. Bennett, that a grant of $14,000 annually be made available for the Canadian Medical Association to assist in carrying out the projects outlined in their request.

Unanimously concurred in.

The meeting was adjourned.

Attached to this was a copy of a telegram dated March 24th, 1937, as follows:—

Dr. R. E. Wodehouse,
Dept. Pensions and National Health,
Ottawa.

Executive accepts the proposals made by Dr. McEachern to the Board of Trustees of the Cancer Fund.

(Sgd.) GEORGE S. YOUNG,
Chairman of Executive Committee,
Canadian Medical Association.

THE COMPLETE STORY REGARDING CANCER, AS EXTRACTED FROM THE MINUTES OF THE EXECUTIVE COMMITTEE, JUNE, 1933, TO OCTOBER, 1936

EXTRACT FROM MINUTES OF EXECUTIVE COMMITTEE AT SAINT JOHN IN 1933

The following recommendations contained in the report of the Study Committee on Cancer were passed by Council to the Executive Committee for study and such action as they should consider advisable:—

1. To arrange for a section in the *Journal*, in which each month some questions relating to diagnosis and treatment of cancer will be dealt with.

2. To prepare from time to time leaflets or booklets dealing with early manifestations of cancer in various parts of the body, for distribution to all Canadian doctors.

3. To prepare and distribute, when the time is opportune, literature for the enlightenment of the laity on this subject.

4. To arrange for special meetings at regular intervals in all local and district medical societies throughout Canada at which speakers secured locally and from adjacent medical teaching centres will give addresses on some aspect of the cancer problem.

5. To arrange through the Provincial Medical Associations for speakers to address public meetings on this problem.

6. To use its influence with the provincial associations to appoint a Provincial Cancer Committee in all provinces, where this step has not already been taken.

7. To cooperate with the Provincial Cancer Committees in organizing a local committee in each organized hospital of 100 beds and upwards. This local committee will study all records of cancer cases admitted to the hospital and take the responsibility to see that they are as complete as possible. It will undertake to make a tabulated synopsis of each cancer record on a form provided by the Department of the Canadian Medical Association. These forms will be kept available in a loose-leaf binder in the hospital. The committee will provide a speaker at each monthly staff meeting, who will give a brief address on the early signs of cancer in some site, using the hospital records to give point to his communications.

Moved by Dr. FitzGerald, seconded by Dr. Patch:

That the members of the Executive Committee be requested to study these recommendations carefully between now and the autumn meeting of the Committee, such study to be made both individually and in groups, and that the recommendations be brought forward again at the next meeting of the Committee for such action as may be considered advisable. *Carried.*

EXTRACT FROM MINUTES OF EXECUTIVE COMMITTEE NOVEMBER, 1933

Cancer

Copies of the report of the Study Committee on Cancer as presented to Council at the annual meeting in Saint John, were passed to the Executive Committee for consideration.

Moved by Dr. Primrose, seconded by Dr. Nicholls:

That the report of the Study Committee on Cancer be considered as a whole. *Carried.*

Dr. Bazin.—Is it the wish of the Executive Committee to leave out for the present the consideration of an attempt being made to discover the cause of cancer, and to limit our activities to such as would bring about early recognition of the disease and prompt treatment?

Dr. Primrose.—I would not exclude the cause of cancer. It is not necessary that we restrict ourselves to this extent.

The following recommendation from the report of the Study Committee on Cancer came up for special consideration:—

"That the Council of the Canadian Medical Association take the initiative in organizing a Canadian Society for the Control of Cancer. This Society will be open for membership to all citizens, who are interested in the cancer problem. The membership fees and contributions received will provide a fund, which will finance the cost of the various activities in connection with the dissemination of information about cancer to the medical profession and to the lay public.

This organization would have a branch in each province and a local chapter in all towns and cities, where a sufficient number of people could be interested in the work. Each local chapter would provide a medium through which the public would receive information about cancer in the form of addresses and by distribution of literature prepared by the Cancer Department of the Canadian Medical Association."

Dr. Starr.—What we should have is a very strong, small committee of the Association to be known as the Cancer Committee.

Dr. Patch.—I would go further than that. I would approve the development of an organization outside the Association. We could assist this organization in an advisory capacity if desired, and we could at all times give them our fullest cooperation. I think the proposed organization should be linked up with the British Empire Cancer Campaign.

Dr. Primrose.—I am in entire agreement with Dr. McEachern that some organization should be established. I think it should be somewhat similar to the British Empire Cancer Campaign. I think we should have a Cancer Commission to raise funds. I am of the opinion that this could be done even in these strenuous times, if it were gone about in the right way and I think it could be done by securing a business man to head up such a campaign.

Dr. Fleming.—Certainly there is a wide field of work but one almost hesitates to support the idea of another voluntary health organization. At the same time, if that is the way to do it, we should start out. I think this work should be done by a separate organization but perhaps in the early stages it should be controlled by the medical profession. There is a possibility of this type of work getting into the hands of a lay group in the future whose policy might be opposed to what we would like it to be.

Dr. Primrose.—There is no suggestion at the moment that this lay committee, composed largely of business men, should have anything to do with the work of the cancer organization beyond the raising of funds to support it.

Dr. Fleming.—I rather favour the idea of the control of this cancer organization by the Canadian Medical Association.

Dr. Bazin.—I think we could swing a national organization but we should decide what type of organization it is to be and whether it is to be supported by grants or by membership fees.

Dr. Primrose.—If we commence our organization with the names of a number of prominent men at its head, I feel sure we could raise the necessary money in Canada today.

Dr. Bazin.—Would we be more certain of keeping control of the medical aspect of the work if we initiated it in our own ranks under the direction of our membership and of the profession so far as we could without any funds, and then demonstrate to the proposed organization that we were a growing concern in this matter and require to branch out for the education of the public, and that we consider it better for the education of the public to go through a lay organization rather than through the medical profession?

Dr. Primrose.—The first thing is to collect a sufficient amount of money to have a full time secretary.

Dr. Starr.—I am quite sure the Prince of Wales would not only give us very valuable advice, but might render some assistance in helping to put the plan over.

Dr. McEachern.—There have been a great many men throughout Canada who have been intensely interested in the subject of cancer. What we need is not a discussion of detail but to establish an organization that will carry that out. The more I have thought of this the more I feel that it is absolutely essential that the whole thing be kept under the control of organized medicine. My fear is that, if we form an organization such as has been referred to by Dr. Primrose, perhaps not in

our time but later, this may get out of the hands of the medical profession and they will find themselves in a position where they are dictated to by masterful laymen. There are really two problems in the educational program, one, the education of our own profession in regard to the recording of all the details that are obtainable with reference to each individual case of cancer; two, the problem of educating the public. In this latter, it seems to me that with regard to the problem of finances, our educational program and our request for assistance should not be limited to the few wealthy people of the country, but to every man and woman regardless of their financial condition. We would then have a much larger constituency to carry our campaign to the public.

I would suggest that this Executive nominate a Central Executive Committee with a chairman and nucleus preferably in one of the eastern cities, and empower them to enlarge the Committee by the addition of *ex-officio* members who would be the chairman of the Cancer Committee in each of the provinces where a Cancer Committee has been formed; that they be immediately instructed to select a young active man as Associate Secretary, and that this Association make a loan to finance his activities until a permanent means of financing has been established. The work cannot go on without some enthusiastic individual travelling about Canada, to stimulate interest in carrying it on and to insure some degree of uniformity in doing the work in various parts of Canada. There might also be an advisory council who would aid by correspondence. Each advisory committee would be asked to appoint a certain number of members to this council according to the population of the province. The Central Executive Committee should be asked to decide upon a standard form which would be acceptable to the various cancer committees of the provinces. On this form the histories of each of the cases should be tabulated. Then my own feeling is that it would be wiser to have as an auxiliary body, a lay or medical-lay body, and through that body finances should be secured and facilities be provided for reaching the general public. I would suggest that the Central Executive Committee, nominated by this Canadian Medical Association Executive Committee, be instructed to take steps to form that auxiliary lay or medical-lay body to approach a number of people such as the Prime Minister of Canada and other influential persons, and form a central nucleus of that auxiliary body. The Central Executive Committee nominated by the C.M.A. Executive Committee might be automatically members of the medical-lay body. That would insure a constant bond of union between the two and it would also insure that the lay body would not get control of the matter and put into force some ideas that are not in accordance with the ideas of organized medicine. The duties of that lay organization would be largely to raise funds and to provide for the dissemination to the general public of knowledge regarding cancer. The next step for the lay body would be to organize provincial units and then units in smaller places. There are many people suffering from hopeless cancer who require morphine. The local bodies could sponsor the task of providing that and providing dressings to patients in their homes. I think if the matter were gone at earnestly we would have, in six months, sufficient money to run it for a year. There should be a systematic canvass made of the people throughout the whole of Canada.

Dr. Nicholls.—Would there be overlapping with existing cancer bodies?

Dr. McEachern.—As soon as this central organization is established they would immediately co-ordinate the activities of the existing cancer committees.

Dr. Adamson.—We have a Cancer Relief Institute in Winnipeg which has been in existence for four years. They have impressed upon me that they are very anxious that there should be a Federal organization to co-ordinate the activities and accumulate records, etc. It would be necessary to investigate organizations in the various provinces before anything definite could be done by us.

Dr. Primrose.—Would it not be a good thing to get all these organizations working together? If we started out to raise half a million, I believe if we were to put it into the hands of an organizer, we would have the amount without any doubt. As to the name of such a campaign, I would suggest the Canadian Cancer Campaign and it should be affiliated with the British Cancer Campaign.

Dr. Fleming.—The first thing to do would be to outline a very definite program of what we are going to do, what it will cost, etc.

Dr. Patch.—I am convinced of the necessity for some organization. The only thing is who should do it, whether this Association should do it separately or not. It was then,

Moved by Dr. Patch, seconded by Dr. Adamson:

That the Canadian Medical Association take immediate steps to initiate the formation of a national society for the combating of cancer in Canada, which organization shall co-ordinate all the various cancer organizations now in Canada; and that a Committee be appointed by the Chairman of this Executive Committee to study the question and report to the next meeting of the Executive Committee as to the nature and character of such an organization and ways and means which should be adopted to effect it. *Carried.*

Dr. Primrose was appointed Chairman of this Study Committee on Cancer.

EXTRACT FROM MINUTES OF COUNCIL AT CALGARY, 1934

In speaking to this report, Dr. Primrose stated that the plan his Committee has in mind is a very extensive one. We have been asked several times by the British Empire Cancer Campaign to take some action here in Canada but have not done so. In the proposed work, we desire to raise a sufficient sum of money to have a permanent secretary. We propose to ask the Prince of Wales, as Patron of the Canadian Medical Association, to give his patronage to our Cancer Campaign. We are planning to have a very strong personnel and to effect such an organization as would co-ordinate the cancer work for the whole Dominion. In Saskatchewan, there is a committee in affiliation with the British Empire Cancer Campaign. There are others working in this field in other parts of the country. We should consolidate all organizations in Canada working in this field. This is a progress report only but we would like the consent of this Council to our proceeding along the lines suggested.

Moved by Dr. Low, seconded by Dr. Patch:

That the report of the Study Committee on Cancer be received and adopted, and that the Committee be asked to continue its efforts along the lines indicated in the report. *Carried.*

EXTRACT FROM MINUTES OF EXECUTIVE COMMITTEE, OTTAWA, OCTOBER 30, 1934

REPORT OF THE STUDY COMMITTEE ON CANCER

Dr. Primrose presented the following progress report of the Study Committee on Cancer, of which he is the Chairman:—

A year ago, this Executive Committee asked Dr. Bazin to nominate a Committee to deal with the problem of cancer. Dr. Bazin suggested myself as Chairman, Dr. W. B. Hendry, Dr. H. Wookey, Dr. N. S. Shenstone, and Dr. Duncan Graham. As things developed, I took the liberty of asking others to join the Committee, namely, Dr. Geo. S. Young, Dr. J. G. FitzGerald, Dr. G. E. Richards, and Dr. T. C. Routley.

The Committee met last week and made the following recommendations to this Executive Committee:—

1. That the Executive Committee establish a Department of Cancer Control in the C.M.A.

2. That the present Study Committee on Cancer be given power to add to its personnel other members, both lay and medical.

3. That the Department so constituted take steps at once to organize and direct a cancer campaign in Canada along similar lines to those followed by the British Empire Cancer Campaign.

4. That the Department be given power to collect funds and appoint a permanent secretary as soon as possible.

5. That the Department work in cooperation with the British Empire Cancer Campaign, not necessarily in affiliation.

6. That the work of the Department include the following activities.

(i) The securing of funds.
(ii) The propagation of knowledge concerning cancer and the methods of attacking it.
(iii) The establishment of a cancer library.
(iv) The making of grants to aid cancer study and research.

(With regard to No. 1, "The securing of funds", it is suggested that the Committee secure a guaranteed sum of $25,000 which should be placed at the disposal of the Department to cover initiation and the first two years' expenses; and that some plan of raising funds be put into operation immediately, for subsequent expenses.)

The Chairman further reported that, in the opinion of the Study Committee, there should be an Executive Committee formed, with Chairman, Vice-Chairman, Secretary, and other personnel; and there should also be committees such as the following:—

A Scientific Advisory Committee.
An Investigation Committee.
A Radiology Committee.
An Appeal Committee.
A Finance Committee.

It was suggested that the Secretary should propagate information concerning the principal lines of attack in operation the world over in the fight against cancer. The following points were outlined:—

(*a*) The attack against the cancer cell and the chemical reactions that occur within it.
(*b*) Cancer producing substances—Petroleum in various forms, the hormone "œstrin", etc.
(*c*) Facts regarding anti-cancer serum.
(*d*) Hereditary factors in cancer.
(*e*) Chemical substances which destroy the cancer cell without being harmful to the normal cell, *e.g.*, lead salts.
(*f*) Cobra Venom—no definite results.
(*g*) Biochemical investigation—in particular the metabolism of carbohydrates as sources of energy. The biochemical results of radiation on living cells.
(*h*) Immunity.
(*i*) Grading of malignant tumours.
(*j*) The cancer producing properties of commercial lubricating oils.
(*k*) The serum test for cancer.
(*l*) Radium—proper dose and legitimate field for employment. The bomb.
X-rays.

It is proposed that a cancer library should be established, of circulating type, made available to all parts of Canada, and under the control of the Secretary. This should contain periodical literature and other books or articles bearing on cancer.

There should be a national appeal for funds. The Committee suggested that, for the first two years of operation, we would require $25,000—$12,000 for each year; but there must be additional funds collected to provide for the later period. It was also suggested that the capital sum subscribed should be sufficient to provide funds for research in various directions.

Regarding the Secretary, it is necessary that he be a medical man with special qualifications. It would be necessary for him to prepare pamphlets and booklets from time to time, for distribution to the medical profession and the general public. It is suggested that the headquarters for the present be at the office of the General Secretary in Toronto; and that, as times goes on, the organization be enlarged to include Committees in the various provinces of Canada and also in the larger cities.

As the Prince of Wales is the Patron of the C.M.A., it has been suggested that we ask him to allow his signature to be attached to a special letter to be used in an appeal to the public for funds. In addition to the appeal to the public, we would be at liberty to approach prominent persons and perhaps Governments—Federal, Provincial and Municipal.

Moved by Dr. Primrose, seconded by Dr. Bazin:

That this report be received and adopted. *Carried.*

Dr. Bazin.—I would like to congratulate Dr. Primrose and his Committee on the very thorough study they have made of this difficult problem. It strikes me that, in addition to the endowment funds, the benefits to be derived from a small annual fee would mean not only revenue but sustained interest in the work of the Department. It seems to me it would be wise for us to suggest to the Committee on Revision of By-Laws that, in as much as the C.M.A. has now arrived at the place where it is necessary to secure the cooperation, through its Departments, of a number of lay people, some provision should be made for another group of members which might be called Associate or Sustaining Members who would feel that they were working closely with us in this Department of Cancer Control of the Canadian Medical Association.

Dr. McEachern.—In the first place, I would like to congratulate Dr. Primrose and his Committee on the progress they have made. I am delighted that the C.M.A. has undertaken this activity, and, in as much as this is open for free discussion, would offer one criticism. I fail to see where any provision is made for securing the active cooperation of the rank and file of the profession in bringing about early diagnosis of cancer. While we look forward to the ultimate discovery of the cause of cancer and the discovery of some treatment other than we now have, we should take advantage of all the information which is at present in our possession, which is that, given the early recognition of cancer, it can be cured; but the crux of the situation is that these cases are not discovered sufficiently early, and a large number of them could have been cured had the doctor who first saw the case been sufficiently alive to the early manifestations of the disease. It is necessary to arouse interest on the part of the general practitioner in the study of the history of every cancer case which presents itself in order that the early signs of cancer in various sites might be made more familiar to the rank and file of the profession. Some progress along this line could be made by the establishment of cancer clinics or cancer study groups in every hospital of 100 beds and over. This would bring about an increased ability to recognize the early signs of cancer. I should like to see included in the activities of this committee,—"Interesting the staffs of all hospitals of 100 beds and over, in making an intensive study of the history of every case of cancer that comes into the hospital." Even if it is a late case, the study of the early manifestations that were evident in that case might serve to remind the doctors of symptoms which they had neglected.

Dr. Primrose.—I appreciate Dr. McEachern's remarks. I think the point he mentions might be included under the second item—"The publication of information reference cancer"; but, in order to safeguard it, I would add another paragraph, as follows:—"All other activities which, in the opinion of the Committee, would be valuable in the control of cancer in Canada".

Moved by Dr. Primrose, seconded by Dr. Bazin:

That the report as amended be approved. *Carried.*

Dr. Graham.—Do you think the lack of early diagnosis is due to failure on the part of the public or on the part of the doctor?

Dr. Bazin.—The chief fault rests with the doctor, not because of lack of knowledge but because of lack of the sense of responsibility.

Dr. Graham.—I think there are two sides to this. The education of the public is very important as well as the education of the doctor.

Moved by Dr. Primrose, seconded by Dr. MacKenzie:

That, in the meantime, until such time as the Committee may wish to amend their present views, the Study Committee on Cancer be empowered to act for the Association. *Carried.*

Re LAY MEMBERSHIP

It was pointed out that our membership is now confined absolutely to medical graduates,—in fact, many of the scientific teachers in universities are not eligible for membership in the C.M.A. The opinion was expressed that it would be advisable for the Committee on

Revision of By-Laws to study the question of the possibility of having other than medical membership, on a restricted basis. This is important in connection with the future work of the Committee on Cancer because a large membership connected with the Department of Cancer Control would stimulate interest in many ways. The fee, of course, would be comparatively small.

Dr. Primrose.—Would like to have a ruling as to whether or not, at the present juncture, our Committee should ask for the cooperation of certain lay persons who, we think, would be valuable in connection with our plan. It is essential for the initial success of the scheme that we should be able to cooperate with certain lay members in constituting what we might call a Grand Council. I would like to get together a number of very prominent persons.

Dr. Young.—I take it that is provided for in the report which gives the Committee authority to call together lay and medical people.

Dr. Bazin.—The British Empire Cancer Campaign has a Grand Council, and each branch has a lay membership who are charged a small annual fee. They ascribe much of their success to these lay members. They are more interested and more appreciative when they contribute to the plan.

Dr. Primrose.—Is it your opinion that it is not possible, under our present constitution, to add to our Committee lay members?

Dr. Young.—This is a special study committee. I do not know anything in our Constitution which would prevent your doing this.

Dr. Bazin.—As I interpret it, Dr. Primrose's Committee increases its membership by the addition of a lay personnel who are to act in an advisory capacity to this special committee of this Executive. Would like to suggest that the Committee on Revision of By-Laws study this matter, and, if they consider it is not necessary to change the By-Laws to permit of this, well and good.

Dr. Primrose.—Should we add another clause to the resolution already passed, to the effect that the Committee be authorized to get influential people in the community to act on a Grand Council which would help us to further the interests of this Department.

Dr. Routley.—Does not the word "personnel" take care of that?

Dr. Primrose.—I do not want these persons on the Committee. I want to be able to have the sanction of this Executive to call together a Grand Council for the purpose of furthering this organization, and have it composed of both lay and professional members.

Dr. Patch.—Might I suggest that it would meet all objections if, in recommendation 2, the last four words be deleted and an additional section be added as No. 7—"That the Committee be empowered to secure the cooperation of influential lay members".

Dr. Primrose.—I would prefer to put in another section and leave No. 2 as it is.

Dr. Young.—As we have already approved the memorandum as it stands, why not make this a special resolution?

Moved by Dr. Primrose, seconded by Dr. Patch:

That the Committee be authorized, if need be, to establish something in the nature of a Grand Council, consisting of both lay and medical members, who would be of service in furthering the interests of the Department. *Carried.*

Dr. FitzGerald.—As a matter of information, I would like to ask whether it is contemplated that the Grand Council will be formed prior to the appeal for funds?

Dr. Primrose.—I think that is a point which will have to be considered by the Committee.

Dr. Bazin.—Unless you can show your organization, you will have difficulty in securing funds.

EXTRACT FROM MINUTES OF EXECUTIVE COMMITTEE, TORONTO, APRIL, 1935

INTERIM REPORT OF STUDY COMMITTEE ON CANCER

The following interim report of the Study Committee on Cancer was presented by the General Secretary in the absence of Dr. Primrose, the Chairman.

The Study Committee was composed of the following members of the Canadian Medical Association:—

Dr. G. S. Young, Dr. D. E. Robertson, Dr. N. Shenstone, Dr. G. E. Richards, Dr. H. Wookey, Dr. D. Graham, Dr. W. B. Hendry, Dr. Grant Fleming, Dr. T. C. Routley, Dr. J. G. FitzGerald, Dr. A. Primrose (*Chairman*).

The name of Dr. A. Grant Fleming was added at the last meeting of the Committee on December 13th and it was agreed that copies of the Minutes should be sent to him from time to time.

The first meeting of the Committee was held on April 21st, 1934, when it was suggested that an organization that might be called, "The Canadian Cancer Campaign", should be inaugurated under the ægis of the Canadian Medical Association.

A second meeting of the Committee was held on October 24th, 1934, when it was re-affirmed that some such organization as that suggested at the meeting of April 21st, should be formed and that the matter be referred to the Executive Committee of the Canadian Medical Association.

At this meeting certain suggestions were approved for the formation of a Grand Council and various committees. The following possible activities were approved for submission to the Executive Committee:—

1. To make a national appeal for funds.
2. To propagate knowledge concerning cancer and the methods of attacking it.
3. To establish a cancer library.
4. To make grants for cancer study and research.

These recommendations were duly reported to the Executive Committee along with a recommendation that, "A Department of Cancer Control in the Canadian Medical Association be inaugurated".

The Executive Committee met on October 30th, and agreed to the suggestions of the Study Cancer Committee, authorizing the Committee to proceed with the establishment of a department of cancer control in the Association.

The Committee met again on November 15th, 1934, when the whole situation was carefully reviewed. Correspondence was read from Dr. A. Grant Fleming and Dr. FitzGerald, expressing the opinion that, rather than establish a new department in the Association, it could be carried on by existing departments, *viz.*, the Department of Publicity and Health Education, the Post-Graduate Department and the Department of Hospital Service; also the *Journal*.

It was determined to arrange a conference between Dr. Fleming, Dr. FitzGerald, Dr. Primrose and Dr. T. C. Routley, this conference to be convened on November 17th. Dr. Primrose made the following statement to the Committee:—

"It may be freely acknowledged if the Department for the Control of Cancer in Canada were established without any reference to existing organizations within the Canadian Medical Association, the contention of Dr. Fleming that there would be unnecessary overlapping, is quite true.

There would be no necessity and no intention of permitting such overlapping of which he speaks. The Department, if organized, would undoubtedly utilize and fully cooperate with other organizations within the C.M.A., such as the ones that Dr. Fleming enumerates,—The *Journal*, the Post-Graduate Committee and the Committee on Publicity and Health Education. There should be no overlapping but full cooperation would be sought to the fullest degree.

Dr. Fleming however, apparently objects to the organization of a department for the control of cancer in Canada when he states, 'the creation of a new department means expense and I think, duplication'.

I am of opinion that we cannot go further in our scheme of organization until we know the result of the conference that will be convened with Dr. Fleming, Dr. FitzGerald, the General Secretary and myself on Saturday next, the 17th instant."

The conference was held on November 17th, in the offices of the Association. After full and free discussion, the group unanimously arrived at the following conclusions:—

(*a*) That Cancer in Canada is a subject which has engaged the attention of the C.M.A. and that every effort should be put forward by the Association to accelerate its efforts towards the eradication of this disease.

(*b*) That the C.M.A. by virtue of its organization being spread across Canada, should hold itself responsible for the undertaking of further duties in this regard.

(*c*) That, through the Association's Divisions of Post-Graduate Education, Publicity and Health Education, Hospital Service, and the *Journal*, the machinery is now in existence in the Association to attack the problem more effectively and extensively.

(*d*) During the past eight years, the Association has received and spent gift funds approximating $375,000, these funds having been supplied by Canadian Insurance Companies.

(*e*) At the present time, due to the depression, activities in the Post-Graduate Department have practically ceased. We are glad to state that activities in the Publicity and Health Education Department and the Department of Hospital Service are being continued on grants of $6,000 and $15,000 a year, respectively.

(*f*) In the opinion of the group, the original benefactors, namely, the Insurance Companies, should be approached and advised that the Association should have very substantially increased funds if it is going to discharge the obligations of which it is capable in the field of Cancer Study and Control.

(*g*) It would be the desire of the Association to approach the public generally for funds, but, before doing so, this Conference feels that the assent and *approval* of the original benefactors should be obtained.

(*h*) The Committee feels that the Cancer Control Committee of which Dr. Primrose is the Chairman, should be well advised, in the light of the recommendations made hereunder, to review the situation in its entirety and evolve a plan for early submission to the Sub-Executive Committee, and through them, to the Executive Committee for consideration and action.

The foregoing represents the unanimous opinion of the Conference and this opinion is to be transmitted to the Study Committee on Cancer.

SUGGESTED PROGRAM OF THE CONFERENCE

1. Post-Graduate Lectures, Clinics, Demonstrations, etc.

2. Scholarships, bursaries or fellowships for the further training of leaders in the cancer field throughout the Dominion.

3. Increased activity in the Health Education Department, by all known means at their command,—printed articles, posters, radio talks, public addresses, etc.

4. Increased activity in the Department of Hospital Service, having regard to the proposal of Dr. McEachern that the knowledge and experience of the practitioners throughout Canada who are working in hospitals, may be utilized.

5. An expression of our willingness to place at the disposal of government authorities the services of the Association in connection with the development of a Provincial Cancer Control Program, or a National Program.

6. To make available throughout Canada scientific literature relating to cancer.

The Cancer Committee met again on December 13th, 1934, when the report of the conference was duly presented.

The Chairman stated that he heartily agreed with the findings of the conference because he considered it would be impossible to organize a department for cancer study and to make a success of that venture unless we had full and loyal cooperation of every department within the Association.

After full discussion it was agreed by the Committee to approve of the findings of the conference held on November 17th.

Subsequently, as Chairman of the Cancer Committee, I reported the matter to Dr. J. S. McEachern, President of the Association, dated December 17th, 1934. A copy of this letter was sent to Dr. Bazin who had nominated the personnel of the original committee. Copies of this correspondence are provided herewith including a reply by Dr. McEachern, dated December 27th, 1934, and a second letter from me dated January 5th, 1935.

The whole matter is now referred to the Executive Committee for their further discussion and decisions.

I wish to point out however, that the whole question may now be discussed from a different angle in view of the fact that His Excellency, the Governor-General of Canada, has determined to open a fund for the relief of cancer to be known as "The King George V Silver Jubilee Cancer Fund for Canada".

In a communication from His Excellency, I have been asked to function as one of seven trustees of the Fund.

Under these circumstances, I submit that the Cancer Study Committee may still function but once more its decision may be radically revised as a result of the prospect of securing adequate funds for activities in connection with cancer.

I regret as Chairman of the Study Committee on Cancer, I am unable to be present at the meeting of the Executive Committee. I have not called another meeting of the Cancer Study Committee because, in my opinion, it would confuse the issue to have further discussions at this time. The entire situation will require the careful consideration of the Executive Committee. That body may deem it wise to revert to something approaching, if not analogous with, their original suggestion of a "Department". The views expressed by the "Conference" will no doubt receive careful thought. Whatever scheme is adopted, success could not be attained unless there is full cooperation of the various Departments that at present exist within the Association.

All of which is respectfully submitted.

(Signed) A. PRIMROSE,
Chairman.

In speaking to this report, the General Secretary stated that the Study Committee on Cancer wants direction from the Executive Committee as to what course they should take. Dr. Primrose is one of the seven Trustees of the King George V Silver Jubilee Fund for Canada. It is reported that there is now over $100,000 on hand in this Fund and that the main object is educational, medical and lay. The Trustees will be called together early in May. Dr. Primrose would no doubt like to have suggestions from this Executive Committee as to what course should be taken in connection with the new Fund.

Dr. Young.—I do not think those two objectives (medical and lay education) can be attained any more rapidly than is being done at the present time. I think money should be spent in scientific research. We should make a pronouncement of our views as to how the money should be spent.

Dr. Bazin.—The six items mentioned on the suggested program of the Committee do not include research.

Dr. Graham expressed the opinion that research should be an important part of the work.

Moved by Dr. Meakins, seconded by Dr. Gérin-Lajoie:

That this progress report be received and referred back to the Committee for further study. *Carried.*

It was the feeling of the Committee that research should be included in the program to be undertaken by the King George V Silver Jubilee Cancer Fund for Canada.

Dr. Young.—My understanding of the situation is that all activities of the Study Committee on Cancer have been temporarily suspended according to the last paragraph of Dr. Primrose's report.

Dr. Bazin.—I think it advisable to suspend any action for the present and refer the matter back to the Committee. The former activities of the Cancer Committee and the Executive Committee should be held in abeyance on account of the recent inauguration of the King George V Silver Jubilee Cancer Fund for Canada.

Moved by Dr. Meakins, seconded by Dr. FitzGerald:

That the resolution passed by the Executive Committee on October 30th, be still considered the confession of faith of the Canadian Medical Association and that this resolution be passed to the Committee on Cancer for their information. *Carried.*

EXTRACT FROM MINUTES OF COUNCIL, ATLANTIC CITY, 1935

In presenting this report, Dr. Primrose called attention to the meeting of the Board of Trustees of the King George V Silver Jubilee Cancer Fund for Canada, which was held on June 3rd. The actual amount now on hand for the Fund is $420,589.49. This has been subscribed by 320,154 citizens of Canada. This report was approved.

EXTRACT FROM MINUTES OF EXECUTIVE COMMITTEE, ATLANTIC CITY, 1935

Re KING GEORGE V SILVER JUBILEE CANCER FUND FOR CANADA

Dr. Primrose here outlined the work of his Study Committee on Cancer and also the establishment of the King George V Silver Jubilee Cancer Fund for Canada, pointing out that, as Chairman of the Canadian Medical Association Study Committee on Cancer, he has been appointed a member of the Board of Trustees of the King George V Silver Jubilee Cancer Fund for Canada. Dr. Primrose called attention to the following matters which had engaged the attention of his Committee:—

1. It was recommended that the personnel of the Committee be enlarged to include the Chairman of each Provincial Cancer Committee.

2. It was recommended that all requests for funds either from individuals or institutions should be first submitted to the Provincial Cancer Committee and transmitted by them to the Study Committee on Cancer of the Canadian Medical Association.

3. That, in the opinion of the Study Committee on Cancer, before any money is allocated by the Board of Trustees of the King George V Silver Jubilee Cancer Fund for Canada, a survey should be made of the whole of Canada to bring the cancer problem into full view.

4. That, in the opinion of the Committee, it would be best to spread the capital sum with interest over a period of say ten years.

Dr. Jackson.—Following Dr. Routley's visit to the Dominion Council of Health in Ottawa on June 6th, a special Committee was appointed to draw up certain recommendations to be forwarded to the Board of Trustees of the Silver Jubilee Cancer Fund for Canada. The recommendations follow:—

1. That the necessary steps be taken to insure that the medical profession is kept continuously informed as to the latest developments in regard to early diagnosis and the most effective methods of treatment for cancer.
2. That the necessary action be taken, through the medium of official health agencies, to provide a soundly based, carefully planned and continuous program, having as its object the instruction of the public in regard to the nature of the disease, its earliest manifestations and the necessity of prompt and efficient treatment.
3. That in view of the moderate amount of money available from the Fund, we are of the opinion that no allotment should be made for any new research activities.

General Secretary.—Would it strengthen Dr. Primrose's hands if this Committee, through him, made any suggestions to the Board of Trustees with respect to medical education. In speaking to the Dominion Council on Health a few days ago, I pointed out that the Canadian Medical Association is in a position to carry on post-graduate work. Would it be in order for us to memorialize the Trustees of the King George V Cancer Fund to the effect that the Canadian Medical Association is prepared to undertake post-graduate work along the line of education of the medical profession?

It was the feeling of the Committee that any recommendations which should be made to the Board of Trustees should be left to the discretion of Dr. Primrose who is fully aware of our ability to perform such services as may be entrusted to us.

EXTRACT FROM MINUTES OF EXECUTIVE COMMITTEE, OTTAWA, OCTOBER, 1935

REPORT OF THE STUDY COMMITTEE ON CANCER

Dr. Primrose outlined the business transacted at a meeting of the Study Committee on Cancer held in Toronto on October 28th, 1935, as follows:—

We have ten members of the Study Committee on Cancer residing in Toronto and ten representing the different provinces. In Alberta, there are two Cancer Committees, making two representatives for that Province. I wrote to all the members of the Committee asking for suggestions and received replies from all but three, as follows:—

1. *Dr. Malcolm R. Bow*, Provincial Department of Public Health, Edmonton, Alberta, October 12th, 1935.

Need for co-ordination of the cancer work in various provinces. Canadian Medical Association to give leadership. Field Secretary recommended.

Proceeds of investment of Jubilee Fund utilized on educational work among laity and the profession. Recommend an educational program compiled by Canadian Medical Association Committee and submitted to various provincial committees of Federal, Provincial and City Departments of Health, the Medical Societies, Hospitals, Insurance Companies, and all lay organizations interested, for criticisms or suggestions they may have to offer.

Because of limited income from Fund, monies for *research* work not possible, except possibly a few *fellowships* for selected graduates in medicine, undertaking cancer research in recognized cancer centres.

2. *Dr. W. H. McGuffin*, Calgary, Alta.

Recommend all available money be expended for purpose of educating the doctor in recognition of precancerous lesions and educating public to see their physicians for investigation of anything unusual.

Inopportune to spend money for any form of treatment. Organization necessary for educational program.

3. *Dr. E. B. Alport*, Regina, Sask.

Recommends Central Committee Canadian Medical Association, cooperating with British Empire Cancer Campaign, the American Society for the Control of Cancer and other national bodies of similar character.

DUTIES OF COMMITTEE

1. Establishment of active cancer committees in Provincial Divisions of Canadian Medical Association.

2. Committee to be a central clearing house to correlate the activities of the provincial committees.

3. Collect funds.

4. Educational propaganda.

(*a*) *Profession.*—Collecting a library of cancer literature and information from other cancer treatment organizations. Disseminating this information to the profession through post-graduate teams, publications, both journal and pamphlet, and through provincial cancer committees.

(*b*) *Lay.*—Approves program already outlined by Canadian Medical Association Committee but would add a talk on "Surgery in Cancer", to the proposed list of subjects.

(*c*) *Research.*—Suggest that this be left in abeyance for the present. Advocates a patronage lay group to be attached to the general committee, for education and collecting money.

The Saskatchewan division of the Canadian Medical Association recently approved the formation of cancer study groups in hospitals of 50 beds and over, the chairman of groups in hospitals of 100 beds and over, to be automatically members of the Provincial Cancer Committee.

Recommend a scheme of bursaries from Jubilee Fund to permit a limited number of rural practitioners to take a short refresher course at either of our treatment centres. Expects to be in Toronto in November.

4. *Dr. Gordon S. Fahrni*, Winnipeg, Man.

Makes no suggestions but desires Minutes of our meeting after which there may be certain suggestions which the Cancer Institute of the Province may bring forward.

5. *Dr. G. A. B. Addy*, Saint John, N.B.

(1) He states that New Brunswick Medical Society Cancer Committee suggest first, that part of Jubilee Fund be used to supply radium on loan to provinces, of which at present, they have not a sufficient supply.

(2) That the treatment of cancer should be standardized in Canada through the Central Committee.

6. *Dr. B. C. Keeping*, Department of Public Health, Charlottetown, P.E.I.

States that at the last meeting of the Dominion Council of Health, in Ottawa, he concurred in the resolution that we brought forth at that time and has no further suggestions to offer at present.

7. *Dr. A. T. Bazin*, Montreal, dated August 21st, 1935.

Canadian Medical Association is primarily qualified to assist in the control of cancer in Canada by means of education of the medical profession and of the public.

1. *The Profession*—
   - (*a*) Post-graduate extra-mural lectures.
   - (*b*) Hospital staff organization.
   - (*c*) The *Journal*.
2. *The Public*—
   - (*a*) Addresses to public meetings.
   - (*b*) Publications.
   - (*c*) Radio broadcasting.
   - (*d*) Newspaper syndicating.

Lectures and clinics devoted to cancer only would quickly pall. Therefore Dr. Bazin would advocate revival of extra-mural post-graduate lectures and clinics wherever a sufficient amount of money is available and arrange that one-third of the program be devoted to cancer.

Hospital staff organization would be conducted through Department of Hospital Service.

The *Journal*—a special department in each issue devoted to cancer, requiring increase in size of journal and special subsidy.

Education of public carried on through Committee on Public Health—also with special subsidy.

Secretariat.—Should be assumed by General Secretary who should be released from other exacting duties and devote whole time to C.M.A. This would entail adjustment of salary.

3. *Financial*—

	Per annum
Post-graduate lectures.....	$25,000 to $30,000
Journal special subsidy.....	1,000 " 3,000
Dept. of Hospital Service....	1,000 " 3,000
Public Health Committee Staff	1,000 " 3,000
Secretary.....	5,000 " 6,000
	$33,000 " $45,000

The presentation of this scheme to the life insurance companies through the Life Officers' Association, would command sympathy and active collaboration and support.

A number of applications for funds have been received but to all of these we have replied stating that the Committee cannot at the present time consider the expenditure of any money as they have no knowledge as to what funds they will be in possession of from the King George V Silver Jubilee Cancer Fund for Canada.

The Committee is very strongly of the opinion that the money available should be devoted to education of the medical profession and the public and not to research. The Committee feels that the limited amount available in the King George V Silver Jubilee Cancer Fund for Canada would be of very little assistance in the research field.

An analysis of contributions to the Fund indicates that the average amount contributed by individuals was 74¼ cents and the conclusion is that very few subscriptions were received from wealthy people.

The Committee finally agreed,—

1. That an intensive educational program, both medical and lay, should be considered by the Board of Trustees as the first obligations of the Fund.

2. That such an educational program, to be of material value and to cover Canada as a whole, would require an expenditure of money considerably in excess of the annual increment which would be earned by the capital sum.

3. That, in the opinion of the Committee, the expenditure annually of a lesser sum than $40,000 or $50,000 would not attain the objective which could reasonably be expected from a properly worked out and conducted program.

For the foregoing reasons, the Committee would respectfully recommend that the capital sum be amortized, say over a ten-year period, and be made available for education in the broadest sense of the term, both medical and lay.

The Committee would respectfully submit that, in its opinion, the C.M.A. is qualified and prepared to administer and conduct an educational program, utilizing such portion of the funds as may be entrusted to the Association by the Board of Trustees.

It was further stated, in the Committee, that, should the Board of Trustees not see fit to grant $40,000 or $50,000 a year to be spent in the manner specified, the Association stands ready to carry out an educational program with whatever funds are made available to it, and to such extent as the funds provided will make possible.

Moved by Dr. Primrose, seconded by Dr. Moorhead,

That the report of the Study Committee on Cancer be received and adopted.

(Not carried *in toto* as subsequent action reveals.)

The Chairman.—In a very broad way, it is extremely important that the C.M.A. should retain the good will of the public largely as an organization which can give advice in matters concerning health. There are 320,000 contributors to the Silver Jubilee Cancer Fund. Their views might not coincide with the views of the C.M.A. If we should ask that all of the money which the Board of Trustees wish to spend in any one year be taken over by the C.M.A. and used at its discretion, is there not likely to be a great deal of criticism on the part of the contributors? Is there not a danger of this awakening a hostility towards the C.M.A.?

Dr. Primrose.—The C.M.A. can do nothing more than apply to the Board of Trustees for funds to carry on a certain program. Dr. Wodehouse tells me that he has received a great many applications for funds. The individuals who contributed to the Fund have made but small contributions. They do not represent, to any great extent, people of standing in Canada. I do not think those have been properly approached and I think we should approach them before long asking for contributions.

Dr. Bazin.—Under date August 8th, I received notice from Dr. Routley that I had been added to the personnel of the Study Committee on Cancer as a corresponding member because I was Chairman of the Cancer Committee of the Province of Quebec Medical Association. I received copies of all minutes of previous meetings of the Committee. I simply made an analysis of those minutes. It was interesting to see the phases through which the study passed. First, the stage at which the C.M.A. contemplated assuming the whole activity. I recognized the inadequacy of the Fund and the Chairman has made some remarks today about the difficulties that might be presented if the C.M.A. should enter upon a program to administer a certain amount of money which the Jubilee Fund was able to provide each year. The Study Committee might suggest a policy similar to that approved by the C.M.A. prior to the establishment of the King George V Silver Jubilee Cancer Fund for Canada. We might say to the Board of Trustees through Dr. Primrose that we have the machinery to put into effect the education of the profession and the public and that we need a certain amount of money to carry this out. If we could secure a grant from the Board of Trustees and perhaps secure a certain amount from the Life Insurance Officers' Association, we might be able to carry out a program similar to what we originally intended.

Dr. Primrose.—If we could suggest that they spread the money over ten years and give us a considerable sum,

this, along with what we may secure from other sources, would enable us to take up our post-graduate work again.

Dr. FitzGerald.—Obviously the work could be done either by the C.M.A. or by setting up some new organization for education in cancer. My view is that the Canadian Medical Association can do it as we have the machinery and we know how to do it.

Dr. Meakins.—I am not sure that I agree with Dr. FitzGerald. I fear very much that, if the Trustees hand over to the C.M.A. $40,000 a year, the people will criticise that action. If, on the other hand, the Trustees, with this money in hand, set up machinery for the establishment of a national cancer association and, although spending all their interest and part of their capital, would also continue to try to raise additional money, it might be delegated to us to take charge of the propaganda as far as it concerns the medical profession. Are we a body that would command the respect of the whole laity in Canada to carry out this particular scheme? I rather think we would be taking on a big responsibility which might be done better in some of its aspects by a national organization in which the laity is represented as well as the medical profession.

Dr. Primrose.—The Trustees cannot do anything but disburse money. They could not establish an organization.

Dr. Meakins.—The Canadian Medical Association only represents 28 per cent of the medical profession in Canada.

Dr. Primrose.—The Trustee Board looks to us for guidance in the expenditure of this money and that is why I am on the Trustee Board. I want the support of this Executive Committee before I can go to the Trustees and place before them what we think should be done, or apply to them for funds. I would stress the fact that this is not simply an idea evolved by the Study Committee on Cancer but it has been endorsed from the Atlantic to the Pacific. I feel that, if we suggest to the Board of Trustees that they hand the money over to a new organization altogether, we would not be acting in accordance with the expressed wishes of the medical profession all over Canada. The Trustees, in any case, have no power to form another body.

Dr. Meakins.—I do not think that even the B.M.A. ever thought they would be given the expenditure of that Fund. I am thinking of the future. I would like to see an organization built up which would go on for years.

The General Secretary.—Is it in the minds of some members of the Committee that the C.M.A. is going outside its own province in sending this communication to the Board of Trustees? As I understand it, the Trustees are concerned with the obligation of distributing money which is in their possession. They are going to be advised by many people as to how they should spend the money. The C.M.A. says to the Trustees,—our organization is equipped and organized to carry out a certain program and we feel, having canvassed the situation, that there is a great need for that program to be carried out. We feel that $40,000 or $50,000 a year could be spent on such a program. We, as an Association, are prepared, within the limits of the finances placed at our disposal to carry out a program. That is what we are preparing to do if they wish us to do it.

Dr. Meakins.—The only suggestion we could give them is to use this $40,000 to $50,000 a year and allow us to spend it for them on propaganda.

At the request of the Chairman, Dr. Primrose then read again the recommendations made in the report.

Dr. Primrose.—I think you are all agreed that an educational program is very desirable and very necessary. The Trustees will be told that the C.M.A. has the machinery to carry out these activities. This was brought out in Dr. Bazin's communication. We have the Department of Publicity and Health Education, the Department of Hospital Service, and the *Journal*. I think it would appeal to the Trustee Board that, if an educational program is advisable, it should be carried out by the C.M.A. rather than that it be done by some other organization newly organized for the purpose. We are asking for something for a specific purpose which we believe we are equipped to carry out. I would not think of putting this forward unless I have the support of the Executive Committee.

Dr. Young.—I think the Committee is agreed up to a certain point and then arises some question.

Dr. Bazin.—It has been moved and seconded that this report be received and adopted and, in that report, are the recommendations of the Committee. This report will be presented verbally to the Trustees by Dr. Primrose and interpreted to them.

Dr. McEachern.—There are some things in the report to which we can all agree and there are others to which I, personally, cannot agree. I do not think it would be good policy on the part of the Executive Committee of the C.M.A. to make any suggestions to the Board of Trustees that they amortize this Fund and take a chance on the whole sum being dissipated in ten or twelve years. Then, when the people who have contributed would ask what had become of the money, the reply would be that the C.M.A. had expended the capital sum rather than the interest derived from it. So far as that aspect is concerned, I, personally, am opposed to the Executive Committee endorsing it. It seems to me it would be better if we discussed the recommendations clause by clause.

It was then agreed that the recommendations be dealt with clause by clause.

Clause 1—That, in the opinion of this Committee an intensive educational program, both medical and lay, should be considered by the Board of Trustees as the first obligation of the Fund. This was approved.

Clause 2—That such an educational program to be of material value and to cover Canada as a whole would require an expenditure of money considerably in excess of the annual increment which would be earned by the capital sum.

Dr. Primrose.—I, personally, am of the opinion that, if we stuck to $10,000 a year, we would probably be open to much greater blame at the end of five or ten years than we would be if we had a much larger sum expended over ten years. We could do something with $40,000 but very little with $10,000. In the Deed of Trust there is a clause which suggests that a residue be retained to keep the capital alive. My Committee is unanimously of the opinion that we cannot do much unless we have a larger amount of money. This is one point on which I wish instruction from the Executive Committee. I want the support of the Executive Committee. Personally, I think it would be a very great mistake not to make this suggestion to the Trustees and, if they see fit to refuse, then the responsibility is on their shoulders.

Dr. Bazin.—Would it not be wise, instead of the second recommendation, that we simply say that, following the first recommendation, the C.M.A., with its experience in post-graduate affairs and in public health education, considers it could undertake the task of education and effectively carry out the program recommended in the first paragraph. The C.M.A. has the machinery to carry out this program. Then leave it to the Trustees to decide about the distribution of their money.

Clause 2 was then approved.

Clause 3—That in the opinion of this Committee, the expenditure annually of a lesser sum than $40,000 or $50,000 would not attain the objective which could reasonably be expected from a properly worked out and conducted program.

Dr. Meakins.—How did you arrive at such a figure?

Reply.—This was worked out after consideration of the amount spent in our post-graduate lectures and also of Dr. Bazin's recommendations.

Dr. Primrose.—We consider that the cancer program would be more effective if linked up with the post-graduate course, supported by funds from some other source.

Dr. Bazin.—We used $30,000 a year for seven years. I doubt very much if we could have had more men speaking or more meetings than we had. If $30,000 were again available to us for post-graduate work and one-third of that time and speaking devoted to cancer, it seems to me it would be more effective.

The General Secretary.—The balance of the budget to which Dr. Bazin refers is for the Health Education

Department and additional secretarial services as well as extra publications in the *Journal*.

Dr. Meakins.—If I were a Trustee, this would seem to me like bolstering up the C.M.A.

Dr. Primrose.—I do not agree with Dr. Meakins. I think we should say definitely to the Trustee Board that the C.M.A. has the machinery to do this and, if we are granted this sum of money, we could do the work.

Clause 3 was then approved.

Clause 4—For the foregoing reasons, the Committee would respectfully recommend that the capital sum be amortized, say over a ten-year period, and be made available for education in the broadest sense of the term, both medical and lay.

The General Secretary.—I think the only purpose this serves is to explain how the $40,000 could be obtained.

Dr. McEachern.—I think it would be well to review our situation. If we go back to the meeting of April, 1935, a resolution was passed in which we reiterated our endorsement of the report of the Study Committee on Cancer to the previous Executive Committee. My recollection was that, along with the educational activities that have been discussed here tonight, it was proposed to create a lay organization which would act in conjunction with the medical profession as a vehicle through which the lay public could have education carried to them and a body which could raise the sinews of war. I do feel that, had we gone on and put that into effect when the Governor-General announced the establishment of this King George V Silver Jubilee Cancer Fund for Canada, we would have had a lay organization extending from the Atlantic to the Pacific which would be of very great value in collecting a fund which would probably have been at least double what it is today. Of course, that opportunity is passed but there still remains to us the opportunity of trying to set up that lay organization which can be used to increase the Jubilee Cancer Fund. We may get from that a small sum of money which will enable us to do a little work and we could then call to the attention of the Trustees of this Jubilee Fund the fact that we could do more if we had the funds.

Dr. Young.—In looking over the past, we will all realize the establishment of this scheme for raising the King George V Silver Jubilee Cancer Fund for Canada was so new that it rather scrapped the existing plans of our Study Committee on Cancer and yet that probably is a temporary affair. I think the organization we suggested will yet come into existence and at the same time there should be that opportunity for the C.M.A. to take part in the formation of such a lay organization as Dr. McEachern suggests. In fact it is the only way the Fund could be implemented from time to time.

Dr. Primrose.—The first thing was that the Executive Committee approved of the formation of an organization somewhat similar to the British Empire Cancer Campaign. Then we decided to use the C.M.A. so far as its different departments would go. Then the cancer campaign came on, and we went no further with our plan. Now we have brought in this report in view of the funds that are now available.

The Chairman then called attention to the clause under consideration.

Dr. Moorhead.—It would not be necessary to stress the matter of $40,000.

Dr. Primrose.—I am not going to press it but just to state that it is the opinion of my Committee. Am I to say that the Executive Committee opposed this clause?

Dr. Bazin.—No, that point is covered in the preceding clause. We only mean that we do not wish to dictate to the Board of Trustees how they are to treat the Fund.

It was then agreed that this clause be deleted. The Chairman made it clear that the reason was not that the Executive Committee was opposed to it but for the reason stated by Dr. Bazin.

Clause 5—The Committee would respectfully submit that, in its opinion, the Canadian Medical Association is qualified and prepared to administer and conduct an educational program utilizing such portion of the funds as may be entrusted to it by the Board of Trustees.

Dr. Meakins.—Does that infer that the C.M.A. think themselves equipped to carry out a program of education of the medical profession? Will there be other organizations engaged in the educational campaign, one for the laity and the C.M.A. for the medical profession? I would like to reaffirm my faith in our original scheme in which the C.M.A. took a very important part. The matter was held up because we had no funds. Now, we have an opportunity to secure funds and we suggest spending the money without any reference to the establishment of an organization such as we then had in mind.

Dr. McEachern.—In the report of the Canadian Medical Association Committee on Cancer as submitted at the Atlantic City meeting, this clause appears,—"Moved by Dr. Meakins, seconded by Dr. FitzGerald, that the resolution passed by the Executive Committee on October 30th, be still considered the confession of faith of the Canadian Medical Association".

The General Secretary.—Supposing Dr. Primrose goes to the Board of Trustees and explains the views of this long discussion and the Trustees say that, in their judgment, they do not consider it wise to distribute the capital at this time but will give $10,000 a year to the Canadian Medical Association for their program, we would then be at liberty to develop the program we formerly had in mind. In going to the Trustees, Dr. Primrose is not placing himself in an untenable position but merely stating what this Association is qualified to do.

Dr. Patch here read the following from the report of the Atlantic City meeting:—

"It was the feeling of those present that any recommendations which should be made to the Board of Trustees with regard to the cooperation of the Canadian Medical Association in the fight against cancer, should be left to the discretion of Dr. Primrose who is fully aware of our ability to perform such services as may be entrusted to us."

Dr. Primrose.—That was an instruction to my Committee and the Committee has reported as presented to you today.

Dr. Young.—Supposing we approve this paragraph, is it not still open to the Cancer Committee to develop the plan which was originally conceived, *i.e.*, the organization of a cancer organization, medical and lay.

Dr. McEachern to Dr. Primrose.—Would it not strengthen your hands in making such proposal to the Board of Trustees if you were also able to say that we are taking steps to organize a lay organization which we hope will be instrumental in increasing the fund available for cancer?

Dr. Primrose.—If you want to go ahead with an organization of that kind and if we submit to the Board of Trustees that we propose to do that, I, as Chairman, could not undertake such a tremendous task. Moreover, the suggestion I have made to implement the Fund consists of sending out to wealthy persons a circular signed by the Board of Trustees, pointing out the great need for additional sums. To go to the Trustees and say that we are now prepared to set up an organization similar to the British Empire Cancer Campaign, I do not think would be wise. We should not commit ourselves to such a tremendous task at this time.

Dr. Meakins.—If we, with a prospect of $40,000 to $50,000 a year, draw back from our former intention, I do not think it looks well.

The General Secretary.—Have the Trustees arrived at any decision with regard to their future policy with reference to increasing this Fund?

Dr. Primrose.—None whatever.

The General Secretary.—If there is a possibility that the Board of Trustees would go out after money, would it not be the part of wisdom to hold our hand until we see what their policy is going to be. They would probably be more successful than we would be. Would we not be well advised to wait until Dr. Primrose comes back from the Trustees and informs us what their plan is going to be.

Dr. McEachern.—Are they not just as apt to say they are busy doing the job they have undertaken and that they feel it is up to us to do this work rather than leaving it to them?

The General Secretary.—Then we could go out and say we have the approval of the Board of Trustees of the

King George V Silver Jubilee Cancer Fund for Canada to do this work. On the other hand, if we go on with our plan and the Board of Trustees advise us that they had it in mind to increase the Fund but would not do so now, we would then be in the position of having to use less money than we might have had allotted to us had we waited.

Dr. Primrose.—If I go to the Board and say the Executive Committee is willing to start the British Empire Cancer Campaign in Canada, if we are granted funds, I think we would find it hard to live up to our promise.

Dr. McEachern.—If you change the name and call it the King George V Silver Jubilee Cancer Fund, we would achieve the same result and have the cooperation of the Board of Trustees.

Dr. Meakins.—I can visualize that, if the new association had a permanent secretary who went across Canada speaking at women's clubs and other service clubs in every town and raising enthusiasm of the great national lay body, I think we could master it. What we are proposing is to take $40,000 or $50,000 and give it to the Canadian Medical Association for post-graduate medical education.

Dr. McEachern.—I agree that we would be able to raise plenty of money for the proposed body.

The General Secretary.—Would it not be helpful if that program had the approval of the Board of Trustees before it was commenced?

Dr. Fleming.—I am not in agreement with a proposal for a new body. It is a question of whether we should organize another national health organization. We are always talking about overlapping. Why organize a new body to undertake the education of the public?

The General Secretary.—I thought this new development was to be a department of the Canadian Medical Association.

Dr. Young.—Would it not be wise for us to do what we can with the clause as it is before us?

The clause was then approved.

Clause 6—Should the Board of Trustees not see fit to grant $40,000 or $50,000 a year to the Canadian Medical Association to be spent in the manner specified, *the Association stands ready to carry out an educational program with whatever funds are made available to it and to such extent as the funds provided will make possible.*

It was agreed that this clause be deleted.

Moved by Dr. Primrose, seconded by Dr. Bloomer:

That the report of the Study Committee on Cancer, as amended, be adopted. *Carried.*

Dr. Graham.—There are a number of people who are convinced that the primary call on this cancer fund should be for research. Is this Committee convinced that all the money should be spent on education and none on research?

Dr. Primrose.—The opinion of the members of my Committee is that none of the money should be used for research purposes. Some members of the Committee have informed me that there is plenty of money available for research purposes.

Dr. Young.—I had the impression that the feeling is that money should be spent on research if the money is available but the amount would be so small as to be of very little use and it would be better spent on education. I do not think the Committee were opposed to spending money on research but they felt that where there was so little money, it should be spent on the education of the doctor and the public.

Dr. Primrose.—So far as the British Empire Cancer Campaign is concerned, I do not think their capital is much over the amount of the Jubilee Cancer Fund; but they are constantly bolstering their Fund by special campaigns.

The General Secretary.—I would express the hope that, when Dr. Primrose raises this question of further implementing the Fund, the Board of Trustees be told of our original plan, and, if they are not prepared to take the necessary steps to increase the funds, that they may, of their own accord, give their approval to this Committee doing so. We could then go on with our original program.

EXTRACT OF MINUTES OF EXECUTIVE COMMITTEE, MONTREAL, MARCH, 1936

DR. WODEHOUSE *re* KING GEORGE V SILVER JUBILEE CANCER FUND

The Secretary stated that a communication had been received from Dr. R. E. Wodehouse stating that the application received from the Canadian Medical Association for financial assistance from the King George V Silver Jubilee Cancer Fund for Canada has been filed for consideration along with other requests for assistance.

DR. PRIMROSE *re* LORD MOYNIHAN SPEAKING ON CANCER

The General Secretary presented a communication from Dr. Primrose stating that the Trustees of the King George V Silver Jubilee Cancer Fund for Canada had invited Lord Moynihan to come to Canada and address a series of meetings on the subject of cancer. Dr. Primrose stated that he had assured the Trustees that, if Lord Moynihan should come to Canada, the Canadian Medical Association, through its branches, would be happy to receive him and cooperate in arranging his itinerary.

Dr. McEachern.—It seems to me that we have permitted a confusion of ideas to creep into our cancer efforts, the mixing up of the possible activities of the King George V Silver Jubilee Cancer Fund with the activities of the Canadian Medical Association Cancer Committee. There are two separate and distinct activities which may, or may not, ever interlock; I feel very strongly that every possible effort should be made to organize the profession in the various provinces to do what they can in regard to this question. I am not on the Cancer Committee of my own province but they lay before me all the communications they receive. The last letter which they received from the Cancer Committee conveyed ambitious plans which could be carried out if plenty of money were available. I feel that a useful work could be done without the expenditure of more than a few hundred dollars. If this were done, the Committee could turn to the Trustees of the Fund and say,—here we have an organization that is doing something and there is no body of men in Canada except the doctors who could do this.

Dr. Bazin.—It seems to me that the Canadian Medical Association Cancer Committee is hoping for something to turn up. If we wait for that, we may have to wait for a long time. I think our Committee should proceed with its plans. We have to arrange for speakers during the summer to go to different medical associations. How would it do to have these speakers give something on cancer?

Dr. Meakins.—I think we have to do better than that. A little while ago we came to the conclusion that something in the nature of prolonged effort should be undertaken. Through the early recognition of tuberculosis, the disease is gradually declining. I think the same could be done in the case of cancer. You may say,—one is infectious and the other is not. That is so, but we must admit that the high mortality of cancer is due to the fact that it is recognized long after it is too late to treat it. I would say that the organization of a campaign against cancer should be placed on the same plane as the organization of the campaign against tuberculosis. We should have an organization of both lay and medical people and keep the activity going year after year. I think we are grabbing for money and not getting down to brass tacks. I do not think the Tuberculosis Association, when they started, had much money. It is a matter of interesting people whose friends have died of cancer, and people with money.

Dr. Bazin—In Vancouver they are very active in developing an organization of just that type, both lay and medical.

Dr. MacKenzie.—It seems to me that a field secretary might be of great assistance in this work, a man who could give talks to hospital groups.

Dr. Graham.—A program was drawn up such as Dr. Meakins and Dr. McEachern speak of, about six months before the King George V Silver Jubilee Cancer Fund was launched, *i.e.*, a committee on education of the

medical profession and the public, making cancer an important topic, taking up its diagnosis in different parts of the body and methods of treatment. A program was drawn up which included what Dr. MacKenzie has referred to, that is, a secretary who might go across Canada and bring this subject before provincial associations. An estimate was made of the cost of such a program and the idea of having lay and medical organizations, such as Dr. Meakins referred to, was discussed. Just at that time, the King George V Silver Jubilee Cancer Fund was launched. Our Committee had in mind an expenditure of about $25,000 a year. When the other campaign was started, the Canadian Medical Association felt that it was not wise to initiate two campaigns. The Trustee Board was then constituted and the Chairman of our Committee on Cancer was made a member. The invitation to Lord Moynihan is the first sign that any action has been taken by the Trustee Board. I think we should decide whether we are going to act independently or not. I am quite in favour of an educational campaign. I think it would be a mistake for us at the present time, in view of the activity of the Trustees of the King George V Silver Jubilee Cancer Fund, to attempt an organization as large as we contemplated. The Trustees seem to be contemplating something in the nature of a large lay organization. Let them go ahead with their plans for a larger fund and a statistical study, etc. When they get the thing going, we should be prepared to demonstrate our ability so that they would accept our Committee as their medical committee instead of appointing another committee. There should be a great deal of education of the medical profession in early diagnosis of cancer.

Dr. McEachern.—I am quite convinced that, while broad statements are made about cancer being a public health problem, the education of the public can most effectively be carried on through the family physician if the family physician could be aroused by a persistent, constant stimulation to keep in mind the early signs of cancer and, in turn communicate warnings about cancer to the families under his care. Our activity could be most effective if small groups of medical men were organized all over the country and educated to recognize the early signs of cancer so that the family physician, when opportunity presents itself (and that would be almost daily) would spread the necessary information to the public. In the last analysis, I think the family doctor is going to be the one we must depend on and, if he is going to be of any use, he himself must be educated. At the Saint John meeting in 1933, Council accepted the recommendations of the then Cancer Committee and passed them on to the Executive Committee to take action and put the recommendations into effect. In November, 1933, the Chairman of the Cancer Committee was appointed with power to form his Committee and go ahead and carry out these recommendations. I think we should pass a resolution urging the Cancer Committee to carry out the instructions given them in 1933, in whole or in part.

It was finally moved by Dr. McEachern, seconded by Dr. Bazin:

That this Executive Committee authorize the Study Committee on Cancer to carry out the instructions given them at the annual meeting in 1933. *Carried.*

Dr. MacKenzie.—What does this program call for?

Dr. Bazin.—Education of the profession and the public.

Dr. MacKenzie.—The cancer question, I think, is well looked after in the larger centres. The greatest need is to get information to small hospitals and small groups of doctors. We say we insist on having the instructions of 1933 carried out. That is very vague.

Dr. Young.—At the time this program was planned, it was understood that it would require money. When the Committee was discussing the way in which money could be raised, the Silver Jubilee Cancer Fund came on the scene and the most natural thing in the world was for the Committee to wait and it has been waiting ever since. There are extenuating circumstances as far as the Committee is concerned.

Dr. MacKenzie.—None of us doubt the sincerity of Dr. Primrose and his desire to get on with the campaign. To this all the Committee agreed.

Dr. Young.—No. They have been waiting to see if funds would be available.

Dr. Bazin.—I am inclined to think that, if we direct someone to have a chat with the proper individual stating our plans and that we require money and had hoped to get some from the Jubilee Cancer Fund, I am inclined to think that we would get some. If we had $10,000 we could go ahead. I am referring to outside sources of funds.

Dr. Meakins.—We must have an organization first and show that we are in earnest in the matter.

Dr. Bazin.—I would suggest that Dr. Patch explain the situation and see if there is a possibility of getting some funds from a source he knows.

Dr. Patch.—It has been explained and there is no possibility for at least eighteen months.

The General Secretary.—I feel that it is now in order for me to raise this question because Dr. Primrose is not here,—What budget are you proposing to place at the disposal of this Cancer Committee? You instruct that the Committee get on with its job and the job requires money. They cannot make bricks without straw. We all recognize that it requires money. The first question the Chairman will ask is "What appropriation is my Committee to get for this work?" Is it not a fact that the delay up to the moment has been due to lack of money?

Dr. Meakins.—Very likely that is so. The Committee in 1933 went as far as they could without money.

Dr. McEachern.—The present Committee could go very far without much money except what is involved in the purchase of stationery and postage.

The General Secretary.—Perhaps that is true but I do feel that the Committee should be told what it may spend. I think the Committee should be guided by the Executive as to what their appropriation will be.

Dr. Patch.—I must point out that we have no money to spend. We have only enough for the expenses of the Association as budgeted for the year.

Dr. Meakins.—Could the central office provide the Committee with stenographic service, stationery, postage, etc.?

The General Secretary.—Yes, we could.

Dr. Graham.—It seems to me that there are two questions involved,—one is that the Executive Committee bring in recommendations as to what the future policy of the Canadian Medical Association should be in view of the establishment of the Silver Jubilee Cancer Fund. I think that should be clearly defined. I think there was a feeling that the Jubilee Cancer Fund adopted in principle the plans that the Canadian Medical Association Committee had evolved the previous year,—that is, education of the public and the profession and funds for research. There is a feeling in the local Cancer Committee that it is not advisable for us to appeal for funds to the lay public to any extent as long as another body is appealing for funds. The Trustees feel that they must now go out and attempt to raise additional funds each year. We learn that the yearly expenditure of the British Empire Cancer Campaign is about equal to what they have in the treasury. They have no endowment fund. Our Committee recommended to the Jubilee Cancer Fund that they take about one-half of the Fund and spend it within the next four or five years. If we are to have one of our members a member of the Trustee Board of the Jubilee Cancer Fund, we must develop a policy that is not in conflict with the policy of the Jubilee Fund. We should ask the Committee to bring in recommendations to the next meeting of the Executive Committee as to what our policy should now be. In the meantime, we, through the provincial committees, should request that at least one day of the provincial annual meetings be devoted to cancer. I think that our speakers going east and west should make cancer a prominent topic in their programs.

The General Secretary.—I would like to point out that Dr. Primrose wishes to know, in the event of Lord Moynihan not being able to come to Canada, if the Executive Committee has any other names to suggest.

It was the opinion of the Executive Committee that the members of the Study Committee on Cancer would be in a better position to suggest alternates.

EXTRACT FROM MINUTES OF COUNCIL, VICTORIA, JUNE, 1936

Attention was called to a resolution passed by the Executive Committee to the effect that the King George V Silver Jubilee Cancer Fund for Canada be asked for from $12,000 to $15,000 a year for five years for an educational campaign of the medical profession and the public.

Dr. J. H. MacDermot.—British Columbia has an active cancer campaign which includes the laity. The public does not want to be educated. They want facts and news.

The general opinion of Council was that in each province steps should be taken to interest business men in order to secure money to be used in a cancer campaign.

It was finally agreed that Council should pass this matter to the incoming Executive Committee for consideration and action.

EXTRACT FROM MINUTES OF THE EXECUTIVE COMMITTEE, OTTAWA, OCTOBER, 1936

Re CANCER STUDY COMMITTEE

In August, 1936, the Nucleus Committee met in Calgary. After reviewing the instructions contained in the Minutes of Council and Executive together with the progress reports of the Cancer Committee up to June, 1936, certain conclusions were arrived at.

The first obvious conclusion was that we had no money.

The second was that if the various provincial cancer committees would cooperate, a part at least, of the program which we were asked to carry out could be put into effect in spite of our impecunious state.

The third conclusion can not be so briefly stated. The medical profession must recognize that a radical change has taken place in Canada since June, 1933. Then, there was no organized body to which the people of Canada might look to assume responsibility for coordinating all the forces which might be used in the control of cancer in Canada. The Canadian Medical Association at that time proposed to arrogate to itself the responsibility. Early in 1935 a Board of Trustees was established to administer a fund known as the King George V Silver Jubilee Cancer Fund for Canada. That Fund is to be used specifically for the purpose of *reducing the mortality from cancer in Canada.*

The people of Canada have a right to look to, and are looking to, that Board of Trustees for leadership in the campaign against cancer.

Your Nucleus Committee concluded that it was the duty of the Canadian Medical Association through its representative on the Board of Trustees to urge upon that body that it take some steps to set up a nation-wide organization for the control of cancer. It suggested that this organization be composed of not only individuals but organized groups who would volunteer to work side by side and contribute according to the resources at his or its disposal, aid, in the campaign to reduce cancer mortality.

These conclusions were embodied in a circular letter which was mailed on September 3rd to each chairman of the nine provincial cancer committees who constitute the Cancer Study Committee of the Canadian Medical Association. A copy of the circular letter together with the replies received is attached and forms a part of this report marked "Exhibit A". In the letter you will note it was requested that categorical replies be given to three questions.

1. Will you undertake to set up in each of the organized hospitals of 100 beds and upward in your province, a Cancer Study Committee?

2. Do you endorse the proposed attitude of your Chairman as member of the Board of Trustees of the King George V Silver Jubilee Cancer Fund for Canada?

If you do not endorse it please give in detail a statement of what you consider his attitude should be.

3. What are the activities directed toward the control of cancer which have been initiated in your province under the ægis of organized medicine?

The replies were studied by the Nucleus Committee. The result of their analysis is as follows:—

Question Number One.—The Provinces of British Columbia, Alberta, Saskatchewan, Ontario, Quebec, and Nova Scotia give assurance that the task suggested is either already under way or will be undertaken. New Brunswick unconditionally rejects it. Manitoba expresses doubt as to its value. Prince Edward Island has not acknowledged any of the correspondence. We thus have assurances of cooperation from the representatives of six provinces which contain 80 per cent of the medical and lay population of Canada. These men who offer cooperation are offering to establish something which will form a foundation for organized cancer activity within the Canadian Medical Association.

There are in Canada, according to information provided by our Department of Hospital Service, 121 hospitals of 100 beds and upward. The number of doctors who constitute the staffs amounts in the aggregate to 4,260. One hundred and three of these 121 hospitals are located in the provinces from which assurance of cooperation have come.

The men who volunteer to undertake this work are entitled to all the assistance which the Canadian Medical Association can give them.

Your Committee therefore recommends to Executive that it take immediate steps to set up a Department of Cancer Control within the Canadian Medical Association.

A proposed plan of organization of such a department is submitted marked "Exhibit B". It constitutes a part of this report.

Question Number Two.—British Columbia replies that it hesitates to endorse the proposal without knowing what the policy of the Board of Trustees is. It expresses the fear that a nation-wide campaign to raise money for the Jubilee Cancer Fund might interfere with the success of their provincial campaign to raise funds for the Cancer Clinic of British Columbia.

New Brunswick rejects the proposal submitted in the circular letter. It suggests that the Chairman of the Cancer Committee urge the Board of Trustees to engage for a period of five years a medical man who is an "expert consultant on cancer", that they pay him during that time an annual salary of not less than $10,000 and expenses. That they establish a diagnostic and treatment clinic in each of the smaller provinces and in other areas to which all tumour cases are to be referred for diagnosis and treatment. That the duties of the "expert consultant" shall be to aid the doctors in these clinics. Further that these clinics be each provided with a quantity of radium up to 200 mgms.

Manitoba agrees that a nation-wide campaign to raise funds is desirable. It questions whether it would be wise to delegate to the Trustees of the Fund the responsibility. It fears that this would lead to slowing up the activities of the medical groups, especially the provincial organizations. Manitoba expresses the opinion that the duty of the Chairman of the Cancer Committee as a member of the Board of Trustees would be "to represent to the best of his ability professional medicine in this country".

Here it may be well to interject that the Chairman of this Committee has no right to urge upon the Board of Trustees his own opinion unless that opinion is concurred in, and endorsed by, the executive which appointed him. He cannot represent the opinion of organized medicine in Canada unless he knows definitely what that opinion is. It was for the purpose of ascertaining that opinion that Question Number Two was submitted.

From the Provinces of Alberta, Saskatchewan, Ontario, Quebec, and Nova Scotia came an unqualified endorsation of the proposal regarding the position which should be taken by the Chairman as a member of the Board of Trustees of the Cancer Fund. These provinces contain at least 70 per cent of the lay and medical population of Canada.

We thus have a mandate which by no means represents the unanimous opinion of organized medicine in Canada but which is a nearer approach to unanimity than we have been able to achieve on most other problems affecting the medical profession of Canada in the past.

Up to the present the President of the Cancer Committee has received from Executive only one specific instruction. He was instructed to present to the Board of Trustees a request for money. A copy of the resolution is contained in the circular letter. He will present it.

He has received no instructions as to his attitude as a Trustee regarding the broad question of what steps can be taken to reduce the mortality from cancer in Canada.

Your Committee recommends to Executive that it give him definite instructions. The proposal which was endorsed in principle by five provinces is submitted in greater detail as "Exhibit C" and forms a part of this report.

All of which is respectfully submitted.

(Signed) J. S. McEACHERN,
Chairman, Study Committee on Cancer,
Canadian Medical Association.

EXHIBIT "A"

Re CANCER STUDY COMMITTEE OF THE CANADIAN MEDICAL ASSOCIATION

Dear Doctor:

At the last meeting of the Executive of the Canadian Medical Association in Victoria, Dr. Primrose resigned from the Chairmanship of the Cancer Study Committee.

I have been asked to act as Chairman and have accepted the responsibility.

As you are aware, the Chairman of the Committee becomes *ex-officio*, a member of the Board of Trustees of the King George V Silver Jubilee Cancer Fund for Canada.

The Committee consists of the Chairman of each Provincial Cancer Committee together with myself and a local nucleus.

The General Secretary informs me that the following gentlemen comprise the list of Chairmen of the Cancer Committees of the Provincial Associations:

Dr. J. J. Mason, Medical Dental Bldg., Vancouver
Dr. M. R. Bow, Deputy Minister of Health, Edmonton
Dr. W. H. McGuffin, 224-7th Ave. W., Calgary
Dr. E. B. Alport, Regina, Sask.
Dr. G. S. Fahrni, Medical Arts Bldg., Winnipeg
Dr. W. S. Lyman, 292 Somerset St., Ottawa
Dr. A. T. Bazin, 1414 Drummond St., Montreal
Dr. G. A. B. Addy, 95 Union St., Saint John, N.B.
Dr. N. H. Gosse, 82 Spring Garden Rd., Halifax, N.S.
Dr. B. C. Keeping, Department of Public Health, Charlottetown, P.E.I.

The local nucleus consists of Drs. A. J. Fisher, W. E. Ingram, W. A. Lincoln, D. S. Macnab, W. Merritt, Lola McLatchie, W. H. McGuffin, E. P. Scarlett, J. W. Richardson, W. Hackney, J. E. Palmer, all of Calgary.

If you will refer to the Report of the original preliminary study committee which was presented to Council at the Saint John meeting in June, 1933, you will find that certain recommendations were made to take steps to put them into effect.

You will recall that the members of the Committee who presented that report were unanimous in their conclusions:

(*a*) That Canadian organized medicine could not assume any responsibility for laboratory research work.

(*b*) That the field of the Canadian Medical Association in relation to the cancer problem lay in insuring that all presently known facts relating to cancer be applied clinically.

They were agreed that at present this was not being done because of two factors.

In the first place, too large a number of cases of cancer were not being recognized in the early stages, even when the patient consulted a physician during an early stage of the disease. In the second place, a large number of patients failed to appreciate the possible significance of early signs and symptoms of cancer and in consequence delayed seeking advice until too late.

Based on these conclusions a recommendation was made that the Canadian Medical Association set up within itself a Department of Cancer Control which would inaugurate and maintain a program of education with reference to the recognition of early signs and symptoms of cancer. This program of education was to include the doctors of Canada and the lay public. The specific activities were to consist of:

1. The publication of articles on cancer in each issue of the Association *Journal*.

2. The preparation and distribution to doctors, of pamphlets or leaflets from time to time, calling attention to the early signs and symptoms of cancer in various sites.

3. The establishment of Provincial Cancer Committees by the Provincial Association in each province, a part of whose duties it would be to undertake the formation of a local Cancer Committee in every organized hospital, of one hundred beds and upward in the province, in which a tumour clinic or cancer clinic was not already a part of its organization.

And in as much as at that time there existed no other body which might be expected to undertake the task, that this Department:

4. Take the initiative in the formation of a national lay organization for the purpose of interesting every Canadian in the control of the scourge of cancer. This lay organization would, through its provincial and local units, provide an avenue through which information could be disseminated to the lay public. It would also be an agency through which funds could be raised to ensure the continued prosecution of the work.

5. That post-graduate lecturers be sent to medical groups in every part of Canada if and when funds are available for the purpose.

6. That a full time medical man be engaged to supervise all the activities and to oversee the carrying out of the details of the whole program.

At the meeting in Ottawa in November, 1933, Executive took steps to carry out the instructions of Council by appointing a committee to carry out the program which has been outlined.

During the past two and a half years the Committee has submitted progress reports. In these it has been pointed out that in the opinion of the members of the Committee, the suggested program could not be carried out in its entirety without the expenditure of a great deal of money annually. The Committee had absolutely no money at its disposal.

Late in 1934 the King George V Silver Jubilee Cancer Fund for Canada was proposed by the Earl of Bessborough and a campaign launched to raise money for that Fund. It must be realized that the creation of that Fund, administered by its Board of Trustees, *completely changed the situation* in Canada as compared with that which existed at the time the preliminary study committee brought in its report. This point will be dealt with more fully later in this communication. The Cancer Committee of the Canadian Medical Association expressed the hope that the necessary money might be secured from the Jubilee Cancer Fund. The efforts of the Chairman, Dr. Primrose, to secure financial aid from this source as you are now aware, were unsuccessful.

One question which this Committee of which you are a member must decide is, "How much of the program can we put into effect without the expenditure of Canadian Medical Association money?"

The Nucleus Committee here are of the unanimous opinion that a great deal can be done.

Item 1. "Articles in the *Journal*"—can surely be carried out.

Item 2. "Preparation and distribution of leaflets"—must for the present stand in abeyance, but is later referred to from another angle.

Item 3. "Formation of local cancer committees in hospitals"—can be done immediately if the cancer committee of each provincial association will undertake the task. Will you and your associates undertake to do this job in your own province? An outline of a method of setting these up and of the duties pertaining to them is being forwarded for your information. This is the method which has been in operation in a number of Canadian non-teaching hospitals for the past three years.

Items 4, 5, and 6, are dealt with a little later.

RESPONSIBILITY OF CHAIRMAN OF CANCER COMMITTEE IN HIS RÔLE AS MEMBER OF BOARD OF TRUSTEES

And now we may seriously consider another phase of the duties of the Cancer Committee of the Canadian Medical Association. When the authority which set up the Board of Trustees of the King George V Silver Jubilee Cancer Fund for Canada provided for the Canadian Medical Association the privilege of being represented on that Board, it paid a great tribute to the medical profession of Canada. It conferred upon it a great honour. Great honour carries with it great responsibility. The Chairman of the Cancer Committee dare not evade his responsibility to contribute constructive suggestions to the Board in formulating a policy which it is to follow during future years. He must therefore, ask you, the members of his Committee to instruct him. The Board meets in September. The intervening time is very short.

I am therefore submitting to you my own personal opinion which has been arrived at after discussing the question with the nucleus Committee. I would ask you to give this your earnest and immediate consideration and write to me at a very early date, an expression of endorsation or disapproval as the case may be. In the event of your disagreeing, will you be good enough to give me in detail, a statement of the attitude, which in your opinion, I should assume.

SUGGESTED ATTITUDE WHICH THE CHAIRMAN OF THE CANCER COMMITTEE OF THE CANADIAN MEDICAL ASSOCIATION SHOULD ASSUME IN HIS CAPACITY AS MEMBER OF THE BOARD OF TRUSTEES OF THE CANCER FUND

The reduction of cancer mortality and cancer morbidity is the task of all Canadian citizens whether lay or medical. The maximum result can be obtained only if they cooperate with each other. The Canadian Medical Association is preparing to mobilize its resources toward this end. It asks only that all other units of society do the same.

Effective cooperation can be secured only if all units act under some acknowledged head.

Today the obvious body to assume headship is the King George V Jubilee Cancer Fund for Canada.

Let the Trustees take steps to organize a nation-wide society for the control of cancer under the ægis of the Jubilee Cancer Fund. Extend an invitation to every individual Canadian citizen to become a member, providing for annual, sustaining, and life memberships.

At the same time, extend an invitation to all organized bodies in Canada, who will volunteer to throw the strength of their organized group into the campaign, to become affiliated with the Society. A few such organized groups come to mind such as, Canadian Dental Association, National Research Council, Women's Institutes, Daughters of the Empire, United Farm Women, Teachers' Associations, Provincial and Federal Departments of Health, Canadian Universities, Research Departments. This list may be greatly added to, and in it would, of course, appear the Canadian Medical Association.

The Jubilee Cancer Fund would receive all membership fees, contributions and bequests. It would undertake to finance all expenditures arising from the publication and distribution of literature, the maintenance of supervision over all details of the work of the society by a full time specially qualified medical man who would be provided with an adequate secretariat, the cost of stationery and forms required in the *cancer activities* of the society and affiliated organizations, the expenses incurred in sending out lecturers and speakers in the work of the society.

It would budget for annual expenditures, a sum equal to the total amount received in interest from its investments plus a portion of the estimated yearly revenue from membership fees.

It would preserve the capital investment of the Fund intact and add to it annually as much as possible, bearing in mind that its activities must be maintained over many years—perhaps indefinitely.

In subscribing to this proposal, the Canadian Medical Association would be expected to place at the disposal of the Jubilee Fund all the organized resources which it has developed or may in future develop in dealing with the cancer problem. This action of the Canadian Medical Association would be conditional upon the Fund's undertaking that at no time would it enter into any medical activities without the full consent and cooperation of the Canadian Medical Association.

The Canadian Medical Association would undertake to secure *authors* of leaflets and pamphlets dealing with the *medical* aspects of the society's work.

It would undertake to secure doctors who would collaborate with lay speakers in the work of organizing the national society.

It would be responsible for the selection of medical speakers who would be required from time to time to address medical meetings or public gatherings on the subject of cancer.

Please consider whether or not this idea would be likely to accomplish as much for the Canadian people as would the effort to carry on our program as Canadian Medical Association independent of the Jubilee Cancer Fund.

Is agreement with this proposal fraught with any danger to the Canadian Medical Association or to the medical profession of Canada?

Finally, will you as soon as possible, answer these questions:

1. Quite independent of any possible aid from the Jubilee Fund, will you undertake to set up in the hospitals of your province, local cancer committees?

2. What is your instruction to the Chairman in regard to his duties as member of the Board of Trustees of the Jubilee Fund?

3. What cancer activities have been carried on under the ægis of organized medicine in your province?

For your information, I am here inserting a copy of a letter received from Dr. Routley, under date of July 4th.

"I wish to bring to your attention the following resolution passed by the Executive Committee at our recent meeting in Victoria. 'That the Board of Trustees of the King George V Silver Jubilee Cancer Fund for Canada be asked for an annual grant, for a period of five years of between twelve and fifteen thousand dollars as the Study Committee on Cancer may determine for a program of education of the public and the medical profession, including secretarial services.' "

Again may I urge upon you prompt action, I want to be armed, when I go to the meeting of the Board, with your information and instructions.

Yours sincerely,

(Sgd.) J. S. McEACHERN,

Chairman, Study Committee on Cancer.

EXHIBIT "B"

DEPARTMENT OF CANCER CONTROL

The proposed Department of Cancer Control does not call for the creation of a new organization. It simply demands a re-alignment of existing committees. It is proposed that it consist of a Board of Directors presided over by a Managing Director, with Secretariat.

(The nomenclature adopted in this report is used for convenience in enunciating the idea, but is subject to change by Executive.)

The Department shall be under the control of the Executive of the Canadian Medical Association acting for General Council.

The Cancer Study Committee shall continue to function. Its duties shall be those laid down in the Constitution and By-Laws of the Canadian Medical Association.

Each Provincial Chairman of Cancer Committee shall be *ex-officio* a member of the Board of Directors of the Department of Cancer Control of the Canadian Medical Association.

The Full-time Medical Secretary of any Provincial Association or Division of the Canadian Medical Association shall *ex-officio* become a Director of the Department of Cancer Control of the Canadian Medical Association unless such an appointment is expressly forbidden by the Association or Division employing him.

The Managing Director of the Department of Cancer Control of the Canadian Medical Association shall be the General Secretary of the Canadian Medical Association. He shall be empowered to appoint as his Secretaries, the Associate Secretaries of the Association as well as any other Secretary or Secretaries who may in future be appointed by Executive.

The Managing Director shall be authorized to use the Lay Secretariat of the Canadian Medical Association or of any of its Departments in the work of this Department. The Board of Directors of the Department of Cancer Control shall be permitted to co-opt any standing or special committee of the Canadian Medical Association to facilitate the carrying on of their work, such for instance as the Editorial Board, the Post-Graduate Committee, the Department of Hospital Service, etc., etc.

Duties of the Department of Cancer Control

The immediate duty shall be:

1. (*a*) To set up in each organized hospital of one hundred beds and upward in Canada where no tumour clinic or cancer committee already exists, a cancer committee.

(*b*) To provide each such hospital committee with an outline of its duties and a set of working rules.

(*c*) To provide so soon as may be a "form" on which the early signs and symptoms, the diagnostic measures (biopsy or otherwise), which have confirmed the diagnosis, the treatment, the immediate result, and the follow-up notes may be tabulated so that some measure of uniformity will be ensured.

(*d*) To take immediate steps to secure the cooperation of an "Authorship Committee" who will provide a series of leaflets giving a brief outline of the early signs and symptoms suggestive of cancer in each of the more common sites. These could be multigraphed in sufficient numbers to provide one of each to each Chairman of a Hospital Committee for the guidance of those who undertake to give the monthly addresses.

(*e*) To secure from the same source a number of addresses suitable for delivery before a lay audience in the event of the organization of a National Lay Organization being undertaken.

This suggestion is made because of the fact that on occasion exaggerated and overoptimistic statements have been made by doctors from the platform and in the press.

2. To undertake any additional activity which Executive may from time to time instruct it to carry out.

Provincial Sub-directorates

For the purpose of carrying out the work effectively, there shall be in each province a sub-directorate acting under the instructions of the Board of Directors of the Department of Cancer Control of the Canadian Medical Association. The Chairman of each Provincial Subdirectorate shall be the Provincial Member of the Board of Directors. (Chairman of Provincial Cancer Committee.)

The members of his sub-directorate shall be the members of the Provincial Cancer Committee. (Here it is urged that the Chairman of each hospital Cancer Committee becomes *ex-officio* a member of the Provincial Cancer Committee.) In the larger provinces, a number of areas under a sub-Chairman might be established.

The Department of Cancer Control of the Canadian Medical Association should exert its influence over Provincial Medical Associations to have them provide speakers on cancer at annual Association meetings as well as at District meetings.

It should submit semi-annually or annually, in the pages of the *Journal* or a supplement of it, progress reports showing the extent of work accomplished.

In the event of the larger medico-lay organization not becoming an accomplished fact, the Department of Cancer Control might seek the authority of Executive to approach the Federal Department of Health to have it defray the cost of publication and mailing of cancer literature prepared for the education of doctors.

N.B.—The Department of Labour prepares and distributes an enormous amount of literature annually.

J. S. McEachern,
Chairman, Study Committee on Cancer.

Cancer Committees in Non-Teaching Hospitals of 100 Beds and Upward

The purpose of establishing these committees is:

(*a*) To secure complete and carefully recorded histories of all cancer cases admitted to the hospital.

(*b*) To have available for future study records of treatment and reports of the subsequent progress in "follow up" notes for every cancer case.

(*c*) To "pool" the experience of the staff and give to every member an opportunity to become familiar with the early signs and symptoms of cancer in various sites.

(*d*) To enlist each member of the staff in a campaign to instruct his own clientele in the early signs and symptoms of cancer whenever opportunity offers.

(*e*) To give to every hospital the opportunity to contribute its quota to the building up of reliable statistics regarding the number of living cancer cases in Canada in a given year. At present these can only be "estimated".

A number of hospitals of this type, in various parts of Canada have already voluntarily organized along these lines. Some of them have evolved an elaborate procedure. One of these might be submitted as a proposed pattern. It will probably be wiser however, at the beginning to suggest only the simplest basic requirements and permit the initiative and originality of each local committee to extend the scope of its activities as local conditions warrant.

Proposed Method of Establishing Local Cancer Committees

It is suggested that the Provincial Cancer Committees in organizing an individual hospital, instead of adopting the democratic but haphazard method of asking the staff to set up the organization, approach one or more members of the staff who are known to be interested in the subject of cancer.

Ask them to accept the responsibility for bringing about the organization. Propose to them that they draw up a "slate" of members of a cancer committee whom they will ask the staff to elect and empower to act.

This group should first be interviewed individually and the consent of each to do the work secured. On the Committee there should, if possible, be at least one surgeon, one physician, a pathologist and a radiologist.

The Committee will undertake:

1. To scrutinize, soon after admission, the history of each cancer case and if the history is incomplete, point out to the attending physician where it is incomplete and ask that the data be secured and recorded.

2. During the patient's hospitalization to require of each person responsible that a description of laboratory investigations, treatment given, and any other relevant data be filed with the history.

3. After the patient's discharge from hospital that "follow up" notes be entered at intervals of six months.

4. To arrange that the hospital authorities provide that the records of all cancer cases be kept in a special file.

5. To provide, at each monthly staff meeting, a speaker who will give a brief talk on the early signs and symptoms of cancer in some specific site.

6. To constantly urge upon the members of the staff that each one undertake to inform his clientele regarding early signs and symptoms of cancer, whenever the opportunity presents itself.

7. To refrain from interfering with the patient but at all times to hold themselves in readiness to give the attending physician any aid in their power, if he should ask for it.

N.B.—A list of hospitals in your province, provided by the Department of Hospital Service of the Canadian Medical Association is enclosed. It may be of value to you.

EXHIBIT "C"

COPY OF RESOLUTION PASSED BY THE EXECUTIVE COMMITTEE OF THE CANADIAN MEDICAL ASSOCIATION AT THE MEETING IN VICTORIA, JUNE, 1936

"That the Board of Trustees of the King George V Silver Jubilee Cancer Fund for Canada be asked for an annual grant, for a period of five years of between twelve and fifteen thousand dollars as the Study Committee on Cancer may determine for a program of education of the public and the medical profession including secretarial services."

PROPOSED BRIEF TO BE PRESENTED BEFORE BOARD OF TRUSTEES OF KING GEORGE V SILVER JUBILEE CANCER FUND FOR CANADA

Mr. Chairman and Gentlemen of the Board of Trustees: As Chairman of the Cancer Study Committee of the Canadian Medical Association, I have been instructed to present to you two communications. The first is a resolution which was passed by the Executive of the Canadian Medical Association in session in Victoria in June, 1936.

A copy of the resolution is submitted. I move that it be received and that discussion and consideration of it be deferred until after the second communication has been received and dealt with.

The second communication, with your permission I shall read:

Under the terms of the Deed of Trust, the Board of Trustees of the King George V Silver Jubilee Cancer Fund for Canada is required to administer the Fund. Subject to certain qualifying conditions they are authorized to expend it "at any time and in any way they may deem most advantageous in search of relief from the high mortality rate from cancer in Canada". That authorization involves responsibility for assessing the value of the measures and activities which purport to reduce the mortality rate of cancer in Canada.

There are only two possible methods of attaining this objective. On the one hand, laboratory research workers may discover the cause of cancer and subsequently, some simply applied non-surgical measure which will render the cause inoperative or neutralize the effect of it after it has begun to act. This at present is only a pious hope and perhaps may not be realized for centuries. The other method is to utilize the knowledge which we now possess about cancer. Briefly stated it consists in this proven fact. Given early cases of cancer in sites which are accessible, a high percentage of cases, can be cured by prompt surgical removal or by radiation or by a combination of both measures.

Cancer mortality is as high as it is today because these cases are not recognized early enough. The failure to recognize them is traceable to two causes. On the one hand, the victim of cancer fails to realize the possible significance of the symptoms and postpones consulting a physician until the disease has progressed to a stage in which no treatment can effect a cure. On the other hand, the victim may, and too frequently does, consult his family physician at a very early stage, only to realize at a later period that his physician had completely failed to recognize the nature of the disease.

It is only fair and truthful to state that in every part of Canada there are large numbers of family physicians who are acutely alive to the recognition of cancer in its early stages. To these men and women more than to any others, should be given most of the credit for whatever degree of success has attended the treatment of cancer in this country. It is therefore obvious that the most important forward step is dependent upon education; education of the public, and education of the family physicians.

By many people, the value of any public service is gauged by the amount of money expended annually. Obviously, this "Board of Trustees" cannot undertake the annual expenditure of large sums of money. I hope to demonstrate to you that work of great educational value can be accomplished with the expenditure of the interest derived from its investments without in any way impairing the capital account as it stands today. That however can only be done with the aid of proper organization of those individuals and organized groups who are anxious and willing to help you.

At this point I would suggest that all and sundry who come to you, either as individuals or as representatives of organized groups seeking financial aid, be reminded that the vital question is, not what the Board can give them but what aid they are prepared to offer to the Board.

A number of well organized groups are prepared to render aid in service. Thousands of individuals are willing to make financial contributions. They are waiting for leadership and some central coordinating force. They look to this Board of Trustees to provide leadership in an orderly approach to the problem.

For years people have asked in vain for answers to reasonable questions; questions which could have been answered had an organization existed which could uncover the truth regarding the questions asked. Today we know that last year eleven thousand sufferers from cancer died in Canada. What of the living? How many sufferers from cancer who underwent treatment are alive, five, ten, fifteen, or twenty years after treatment?

For as long as any of us can remember people have asked about the status of an alleged cancer cure. At the present moment there are at least three of these attracting the attention of people in Canada. To whom shall they turn for unbiased information? They quite naturally look upon information given by the medical profession as being prejudiced.

It seems to many of us to be axiomatic that there is a crying need for a national organization in Canada which would be competent to exercise a supervision over, and bring about coordination of, all activities which claim to aid in the search of relief from the high mortality rate from cancer in Canada. It is not the moral responsibility of any individual or professional or lay organization to undertake to set up such an organization; they would probably fail in the attempt. It is the moral responsibility of this Board of Trustees. It would not fail if it made the attempt.

I am authorized by the Canadian Medical Association to very respectfully propose to you that you set up, or if such phraseology involves violation of the terms of the Deed of Trust, cause to be set up, a national society. For the sake of convenience it may, for the moment, be designated the "Canadian Society for the Control of Cancer". This Society would include within its ranks the "fighting arm" and the "intelligence service" which would help the Trustees of the Fund to discharge the obligation imposed upon them.

The Society would be controlled by officers constituting its Executive Council. The people of Canada would be invited to become members, provision being made for annual, sustaining, and life memberships. All fees, donations and bequests would be turned over to the Trustees of the King George V Silver Jubilee Cancer Fund for Canada.

All organized bodies who would volunteer to contribute their organized strength to aid in the fight against cancer would be invited to become affiliated with it. These would include such organizations as Canadian Hospital Council, National Health Council, Provincial and Federal Departments of Health, Canadian Nurses' Association, Canadian Dental Association, Canadian Medical Association as well as any other organized bodies which have to do with medical or research activities. In addition there are a large number of lay organizations which might be invited to become affiliated. Examples are, the I.O.D.E., Women's Institutes, National Service Clubs, etc. As a condition of affiliation, each organization would be required to consent to oversight over its cancer activities by an "Inspector" engaged by the National Society. Each would be further required to undertake that it would not engage in any cancer activity which was the special function of any other affiliated body without the special and official authorization of the National Society.

The officers of the National Society would employ a full-time "Inspector" who would be required to exercise supervision over the cancer activities of all affiliated organizations as well as to aid in building up membership in the National Society. This man by reason of the

variety of his duties should have reasonable organizing and executive ability and finally he should be able to speak both French and English. A suggested initial salary for him would be $6,000 and expenses.

The Society would employ a sufficient secretariat. It would set up selected from its various affiliated bodies, committees with sub-committees in various areas of Canada to deal with such problems as lay education, investigation of alleged research activities, investigation of alleged cancer cures, finance, etc.

The Executive Council would recommend to this Board of Trustees the payment of expenditures for salary of full-time "Inspector" and expenses. Expenses of secretariat, and, if and when funds are available, the publication and distribution of literature dealing with cancer activity. Further, when funds are available, they would recommend to the Board, expenditure of money to send out authorities on cancer to address medical and (or) lay groups. Later, if funds become available in excess of the requirements of educational activities, they could recommend for financial aid any individual or group engaged in research which the investigating committee believed showed promise of value. Still later, if financial conditions warrant the other activities suggested in the Deed of Trust may be recommended for subsidies.

Bearing in mind the suggestion made in the early part of this communication, you no doubt are ready to ask, "What have you to offer us?" The Canadian Medical Association is prepared to offer all that it has in the way of organized services to further a program of education. It can offer no more. If the principle enunciated in this brief is rejected, it would be a waste of time to examine the details of the offer. If the principle is accepted, I am prepared to submit in detail what the Canadian Medical Association is prepared to do.

After considering the proposals set forth in Exhibits "B" and "C" the Executive Committee on October 30th, 1936, passed the following resolution:

That Exhibit "C" be presented to the Board of Trustees with the approval of this Executive Committee and with a rider that the statement which refers to the appointment of a medical man as director might reasonably be modified to include a medical man or a lay man;

That Dr. McEachern be authorized to advise the Board of Trustees that the Canadian Medical Association is prepared to carry on, within the limit of its resources, a program as outlined in Exhibit "B";

That the reference which has been made in the memorandum to the request for a sum of money, is to be related to the projected program which the Canadian Medical Association is qualified to undertake;

That, in the event of the Trustees accepting the proposal of Exhibit "C", the Canadian Medical Association will be pleased to defer action in order that it may cooperate fully with the new body to be set up. *Carried.*

Toronto 2, March 8th, 1937.

TO THE MEMBERS OF THE EXECUTIVE COMMITTEE AND THE STUDY COMMITTEE ON CANCER OF THE CANADIAN MEDICAL ASSOCIATION

Re STUDY COMMITTEE ON CANCER

Dear Doctor:

In accordance with instructions received from the Executive Committee of the Canadian Medical Association, I presented the proposals outlined in Exhibit "C", at the meeting of the Board of Trustees of the King George V Silver Jubilee Cancer Fund for Canada, in Ottawa, on February 22nd. The individual members expressed themselves as enthusiastically in sympathy with the general proposal,—the setting up of a national organization which would coordinate and correlate various activities which are willing to work together for the control of cancer in Canada. With one specific proposal, however, they could not accede. For certain reasons which they felt could not be set aside, they declined to accede to the request that they either set up or cause to be set up this national organization. However, they did intimate that, if some other responsible body were to undertake this task, they would extend to it their assistance if that body asked for it.

They hinted that the Canadian Medical Association was the body in Canada best fitted to undertake the job. As a result of this, your Chairman drafted a number of letters outlining the position which the Canadian Medical Association would accept. In this letter, a request was made for an annual grant of at least $14,000 to enable the work of organization and the specific duties outlined in Exhibit "B" to be made possible.

Finally, a proposal was accepted as outlined in Exhibit "D". (See next column.) There the matter rests.

The last communication stating the position of the Executive Committee so far as I have been able to ascertain it up to date, was sent by me to Dr. Wodehouse, Secretary of the Board of Trustees, on March 1st. A copy is enclosed for your information.

At the present moment the situation is that the Executive Committee has committed itself to carrying out the terms of Exhibit "B" within the limits of its resources. It remains for the Executive Committee to endorse the proposal as finally accepted by the Board of Trustees of the King George V Silver Jubilee Cancer Fund for Canada. If the Executive Committee does endorse that, then a cheque for $14,000 will be forthcoming immedately.

Yours sincerely,

J. S. McEACHERN,

Chairman, Study Committee on Cancer.

COPY

184 College Street,
Toronto 2, March 3, 1937.

Doctor R. E. Wodehouse,
Secretary, Board of Trustees,
King George V Silver Jubilee Cancer Fund for Canada,
Department of Pensions and National Health,
Ottawa, Ontario.

Dear Doctor:

On Thursday night, February 25th, I had a conference with Doctors Bazin, Meakins and Patch, members of Executive of Canadian Medical Association, resident in Montreal. It lasted until 2 a.m. On Friday night, I met Doctors George Young, Duncan Graham, T. C. Routley and Harvey Agnew, the Toronto members, together with Dr. Alex. Primrose and Dr. Richards. The last two named gentlemen had been members of the Cancer Committee of last year. As a result I am able to say that the activities outlined in the memorandum submitted to the Board of Trustees stating the purely medical program are already under way and steps are being taken to ensure that the details are carried out.

Very serious consideration was given to the second undertaking, the establishment of a National Medico-Lay Society for the Control of Cancer. It was decided that it was essential that this organization be started "on the right foot" even if a little delay in organizing it resulted from a careful study of methods before the organization is launched.

I find that, on other business of the Canadian Medical Association, Dr. Routley is visiting Great Britain, Norway, Sweden, Germany and France. He is undertaking to study organization methods in connection with the cancer problem in these countries. On his return he will submit his report to Executive. In the meantime, groups here at home will study proposals of methods of organization. The whole thing can then be threshed out in Executive Meeting in June. This should result in establishing a "set up" more free of flaws than would be the case if the undertaking were attacked in a more hurried fashion.

In the meantime the real foundation—the setting up of cancer committees in hospitals—will be proceeded with as rapidly as possible. In this way, when the National Society is established, the medical arm will be fully ready to take its place in the program of lay education. In the meantime, I shall request the Head Office of the Canadian Medical Association to forward to you an official statement of their position and intention.

As you realize, I am only the liaison officer between the Canadian Medical Association and the Board of Trustees of the King George V Silver Jubilee Cancer Fund for Canada. I have no Executive Power; but I can recommend and advise.

Sincerely yours,

(Signed) J. S. McEACHERN,
Chairman, Study Committee on Cancer.

EXHIBIT "D"

The Chairman of the Board of Trustees of the King George V Silver Jubilee Cancer Fund for Canada.

Sir:

I was very glad indeed to have the privilege of being present for the discussion by the Board of Trustees of the submission prepared and approved by the Canadian Medical Association Executive. I understand the Trustees would find it difficult to carry out some of the suggestions made therein. I would like the Board of Trustees of the King George V Silver Jubilee Cancer Fund for Canada to assist the Canadian Medical Association with a grant of at least $14,000 annually to carry out the education of the medical men and the public.

Considering our present status in Canada, I am quite convinced that the education of the medical profession and the public is the most urgent need and the one promising the most immediate helpful results. The plan we suggest of carrying out the education of the medical profession, improving the cancer work in hospitals, and collecting very important clinical statistics which might be assembled and studied, has been given much thought by our Executive and approved as the most efficient. It also very materially stimulates clinical research in the field of cancer.

The factor of educating the public is just as important a need as that of the medical profession. They should go on side by side. The organization of the two in the same community is practically inseparable. The Canadian Medical Association desires to organize a lay and medical cooperative group which would undertake the education of the public and be the means of raising additional funds for combating the ravages of cancer among the people of Canada.

I attach some further details of the educational work which the Canadian Medical Association plans to carry out, in addition to those presented yesterday.

I await the pleasure of the Board of Trustees.

Respectfully submitted,

(Signed) J. S. McEACHERN,
Chairman, Study Committee on Cancer.

Approved.

Following discussion of this report, the following resolutions were passed:

1. WHEREAS your Executive Committee has accepted on your behalf the offer of the Board of Trsutees of the King George V Silver Jubilee Cancer Fund for Canada of a grant of $14,000 a year; and
2. WHEREAS the acceptance of this grant on the part of the Canadian Medical Association entails,
   (*a*) a program of medical and lay education on cancer throughout Canada; and
   (*b*) the formation of a national society for the control of cancer; and
3. WHEREAS, toward the carrying out of the suggested program the Canadian Medical Association will make available all the facilities at its command;

   IT IS THEREFORE RECOMMENDED that Council instruct the incoming Executive Committee to take the necessary steps to organize a national society for the control of cancer.

At the meeting of the new Executive Committee on June 24th, the following resolution was passed:

> That the implementing of the two mandates which have been passed by Council to this Executive Committee in regard to,
> (*a*) the education of the profession and laity in cancer; and
> (*b*) the establishment of a national society for the control of cancer,
> be delegated to the Committee on Cancer with power to act.

REPORT OF THE COMMITTEE ON SPECIALISTS

Mr. Chairman and Members of the General Council:—

The Winnipeg nucleus of the Committee held several meetings during the winter. These were all well attended. The reports of various Committees were studied and the subject was discussed from various points of view.

The Committee is strongly of the opinion that steps should be taken by some responsible body to designate those who are properly qualified to practise in any special branch of Medicine or Surgery. This is necessary both for the protection of the public and in order to raise the standard of medical practice.

The problems consist of:—

1. Setting up reasonable standards for each specialty.
2. Examining the qualifications of applicants.
3. Issuing diplomas or certificates to those who meet the requirements.

It seems unlikely that this can ever be accomplished through the individual licensing bodies of each Province; it would mean a change in all the medical acts and this could certainly not be accomplished in all Provinces. Furthermore, in this matter local (Provincial) control might be undesirable; also uniformity of qualification throughout the Dominion would have obvious advantages.

The Medical Council of Canada has expressed itself as unable to undertake these duties.

The organization of separate "Boards" for each specialty has been suggested. (The Radiological Section of the Association has already made such a proposal.) This would require intensive organization of the members of each special branch throughout the Dominion—a hopeless task; also much special legislation would be required. In the end the boards might always be subject to the criticism that they were closed corporations organized for their own ends and not necessarily for the protection of the public, nor the improvements of standards.

The logical body to perform these functions appears to be The Royal College of Physicians and Surgeons of Canada. They are already in a legal position to grant special degrees by examination. It seems logical that they should have their powers enlarged so that they might also give diplomas or certificates to those qualified in special lines. We understand that the College is prepared to undertake this responsibility.

This Committee therefore recommends that The Royal College of Physicians and Surgeons of Canada be asked to make arrangements whereby they may grant diplomas or certificates to those who demonstrate by examination or credentials their ability to practise in any special branch of Medicine or Surgery.

All of which is respectfully submitted.

J. A. GUNN,
Chairman.

Approved.

In discussing this report attention was called to the following resolution passed by the Executive Committee in October, 1936:

THAT this Committee heartily approves of the establishment of a central board for certification of specialists;

THAT this Committee feels that the Royal College of Physicians and Surgeons of Canada is the body which should fulfill this function;

THAT this Executive Committee will cooperate in any way possible with the Royal College in undertaking this work; and

THAT a copy of this resolution be forwarded to the Royal College of Physicians and Surgeons of Canada before their meeting tomorrow, (October 31, 1936).

The above mentioned resolution was approved by General Council.

REPORT OF THE COMMITTEE ON MEDICAL EDUCATION

Mr. Chairman and Members of the General Council:—

Several problems have been considered through the year by your Committee. One problem, that of *Intern Education and Supervision* has been considered by your Committee in collaboration with the Committee on Medical Education of the Ontario Medical Association and with the Department of Hospital Service of the Canadian Medical Association. This joint Committee is presenting a study in detail of Intern Education and Supervision which will appear under that heading. The recommendations of this joint Committee are:

1. Recent graduates in Medicine would profit greatly if during their internship period their work could be under more supervisory control than is possible at present.
2. Such supervision could be best affected by requiring the internship year for either (*a*) the academic degree of the medical school, or (*b*) the license to practise.
3. Of these two alternatives it is the opinion of this Joint Committee that, while either of these alternatives could effect the supervisory control desired, the requirement of an accredited year of internship in order to obtain a license to practise would achieve this result with a minimum of re-organization.

The Association last year asked that your Committee study the question why medical students in Great Britain are fully qualified to enter the study of medicine at the age of 17 or 18 and graduate at the age of 23 (5 years straight medical course), while our Canadian students do not complete the medical course until they have reached the average age of 25 or 26 years. While your Committee did not go into great detail in a statistical way regarding this problem, their opinion seemed to be that English Secondary Schools apparently graduate into the Medical Course students better equipped to handle a University Course than students from Secondary Schools in this country. British students at the age of eighteen seemed somewhat more mature intellectually than students of that age in this country. Also there was expressed the opinion that the Medical Schools in Great Britain or at least the great majority of them made a selection of their students from a larger number of applications than the schools in this country.

Once again the problem of dual examinations on graduation, that is, first for the degree and then for the license, should be mentioned in this report and a definite recommendation from this Association to the Dominion Medical Council is asked for to simplify this situation. In 1932 your Committee presented a method proposed for conducting one conjoint examination for University degree and licentiate of the Medical Council of Canada. This method was proposed by Dr. A. Primrose when he was Dean of the Faculty of Medicine of the University of Toronto. To bring this matter before this Association once more the method is here presented.

Method Proposed for Conducting One Conjoint Examination for University Degree and Licentiate of the Medical Council of Canada

I. The Methods of the Appointment of Examiners for the Conjoint Examination between the Medical Council of Canada and the Universities in Canada would be as follows:—

A. Medical Council of Canada

1. The Medical Council of Canada would appoint the Main Board of Examiners as at present. The examiners appointed should hold academic teaching appointments in the subject in which they examine. This Board would set the written examination papers for all the centres in Canada as at present.

2. Local Boards of Examiners for the Oral and Clinical Examinations in the various centres where the examinations are held should consist of:

(*a*) One examiner in each subject who is not a member of the teaching staff of the University in the centre where the local examination is held.

(*b*) One examiner in each subject who is a member of the teaching staff of the University in the centre where the local examination is held. This appointment should be made on the nomination of the Faculty of Medicine of the University concerned.

B. The University Concerned

The University in the centre where the Examination is held would appoint:

1. One or more examiners in each subject who would read and mark the answers to the written papers (set by the Main Board) of the candidates from their University. The marks given by these examiners would be used by the University concerned, along with the Oral and Clinical marks, in deciding if the candidate should receive his degree.

2. Examiners for the Local Boards for the Oral and Clinical Examinations:—

(*a*) One examiner in each subject who is not a member of the teaching staff of the University in the centre where the Local Examination is held, would be appointed as an Extramural Examiner.

(*b*) One examiner in each subject who is a member of the teaching staff of the University in the centre where the Local Examination is held.

NOTE.—(The object of the above method of appointing Examiners to the Local Boards is to provide for the same examiners in each subject being appointed by both the Medical Council of Canada and the University concerned in each of the Local Centres).

II. Procedure

1. The candidates in each centre would write the examination paper and attend the oral and clinical examinations in each of the centres in the same manner as at present.

2. The written papers of the candidates from the University in which they have taken their medical course are to be read and marked by the examiners in each subject appointed by the University (B.1).

3. These marks on the written papers and the marks given at the clinical and oral examinations will be considered and dealt with as is done at present in the University concerned.

4. The candidates who have been passed by the University will have the degree conferred upon them.

5. The written papers of the candidates who have received their degree from the University will be read and marked by the Main Board of Examiners of the Medical Council of Canada, as at present.

6. The marks given to the candidates by the Main Board of Examiners and by the Local Boards will be considered and dealt with by the Medical Council of Canada as at present, and the successful candidates will be given the Licentiate of the Medical Council of Canada.

7. Candidates in the Local Centres who are trying the Medical Council of Canada Examinations only will be dealt with as at present.

The adoption of this method of holding Conjoint Examinations prevents any candidate from having his examination papers examined by the Main Board of Examiners of the Medical Council of Canada until he has been passed upon and received his degree from his University.

It overcomes the present necessity of candidates being subjected to two examinations within two or three weeks of one another and very often by the same examiners.

The use of Extra-mural Examiners by Universities is copied from the method adopteu at Universities in Great Britain. It has the advantage of broadening the field of the subjects, which has to be covered by the students in their preparation, as they are not familiar with the particular eccentricities of these outside examiners.

In the teaching of Therapeutics your Committee feels that the application of sound physiological principles should be thoroughly stressed. Under these physiological principles three aspects should be mentioned of which attention hitherto given has usually been inadequate, namely—genetics, growth, and mental function. The first is almost a new science and just beginning to appear in medical teaching. Its development during the last few years has been great. Growth, from both its structural and its functional aspects, has, except with regard to a few very elementary facts, for the most part been almost ignored. Mental function, when considered at all, has been dealt with quite perfunctorily, but is beginning to get more emphasis. Yet all these matters are of the utmost importance to medical practitioners, and no proper clinical appreciation of their application either to the preservation or to the restoration of health is possible unless they are sufficiently taught to the medical student during the course of anatomy and physiology.

All of which is respectfully submitted.

F. J. H. CAMPBELL,
Chairman.

A STUDY OF INTERN EDUCATION AND SUPERVISION

by a Joint Committee of the

Committee on Medical Education of the Ontario Medical Association

Committee on Medical Education of the Canadian Medical Association

Department of Hospital Service of the Canadian Medical Association

The Joint Committee

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Department of Hospital Service, C.M.A.—Geo. F. Stephens, Winnipeg; S. E. Moore, Regina; M. R. Bow, Edmonton; A. K. Haywood, Vancouver; A. L. C. Gilday, Montreal; S. R. D. Hewitt, St. John, *Chairman;* Harvey Agnew, Toronto, *Secretary.*

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Part A

Introduction

The internship has become a very essential part of the clinical preparation of the student in medicine. It is now widely realized that the internship provides a most desirable contact and experience with the problems and responsibilities of clinical work, and helps to bridge in a satisfactory manner the transition from the academic to the practitioner's life. Because of the fact that nearly all graduates in medicine are taking internships, and that in many instances such young graduates are devoting not only one but several years of their lives to this form of practical training, it is most essential that the internships offered and accepted be properly organized and provide the interns with that type of training and experience which will best supplement their previous instruction.

The employment of interns implies definite obligations on the part of both the interns and the hospital and its staff. The intern is under definite obligation to give faithful, conscientious service, to fulfil scrupulously his contract and to follow the hospital's rules and regulations. In return for this devotion to duty, the hospital is under distinct obligation to the intern. Without his assistance many of the procedures followed in our hospitals would not be possible and the service to the patients would be impaired. From the viewpoint of the intern he is there to learn; he is giving one or more years of his time and is serving with little or no compensation beyond his maintenance. Therefore the hospital and its staff should feel a real responsibility to provide adequate facilities for clinical and laboratory training and should give the work of the intern proper professional supervision.

With these objectives in mind, the Committee on Medical Education of the Ontario Medical Association, the Committee on Medical Education of the Canadian Medical Association and the Department of Hospital Service of the Canadian Medical Association have jointly prepared this review of the various factors of vital importance in the education of the intern.

Part B

Purpose of Internship

Internship should be considered as an essential part of medical education, offering as it does added knowledge of both the art and the science of medicine. It is now generally accepted that the young medical graduate will take one or more years of internship before entering practice and the actual necessity of this supplementary period of practical clinical training is demonstrated by the increasing number of medical schools requiring the internship year before granting the medical degree. One notes with approval the terminology used in the University of Minnesota Medical School where the intern committee is known as the "Seventh Year Committee".

"The preliminary period of hospital experience should be the most important phase in the development of a competent physician, for it provides the opportunity for the student to apply his knowledge to

practical problems under the direct supervision of qualified physicians and to obtain graduated responsibilities for the actual care and treatment of patient'' (Rappleye).*

The principles of ''self-education'' should be instilled. It is necessary to wean the intern away from the attitude unavoidably engendered by his earlier education, wherein he followed prescribed courses of study. From now on he is ''on his own''.

The internship is of value in acquiring the ''art'' of medicine. Close association with practitioners (most of whom are in private practice and many in general practice) gives the intern an insight into the psychology of medical practice which cannot be imparted so effectively in the crowded undergraduate curriculum. This will stand him in good stead during the difficult first years of clinical practice. He gains experience in the ''humanities'' of practice and becomes initiated to the many external influences which go to make up the professional life.

There is real need for the intern to learn how to organize his time to best advantage. Some would seem to be merely ''putting in time'' and to exhibit no conception of the future application of the experience to be gained. Many future regrets over wasted opportunities could be avoided if the intern could carefully analyze his position and his opportunity, appraise his previous training and his shortcomings and apply himself to mastering what, in his best judgment, he will most need in the future. If additional incentive be needed, a calculation of the monetary value of his time, were he in practice, should have a most sobering effect and make the most irresponsible intern realize that it is costing him money to put in an internship. Without question, ''work'' is the master word; through work ambition should find its outlet.

Because of their greater knowledge of the future application of this possible experience, their opportunity for ''hind-sight'', the members of the intern committee and of the medical staff as a whole should make a strong effort to bring this viewpoint to the serious consideration of the interns.

Part C

Procedures in Intern Education

1. The Medical Staff should be Intern-Minded

It is of vital importance that the medical staff, both individually and collectively, take a real interest in the welfare of the interns. A hospital noted for its expert staff, its research, its equipment, or its results, is not necessarily a good place for intern training. The Canadian Medical Association in its ''Basis of Approval of Hospitals for Internship'' has very wisely insisted that—

> ''Approval is dependent upon the scientific spirit prevailing among the members of the medical staff and in the hospital as a whole, and upon the degree of effort made by the medical staff and the administrative personnel to assist the intern in his work.''

It is recommended that one or more staff men should have lunch with the interns at least once a month; with their feet under the same table and, with an atmosphere of camaraderie, conversation can be free and frank and much invaluable advice and counsel absorbed by the interns in this way.

''. . . . our profession in general have (not) yet fully awakened to their responsibilities in this matter. . . . The teacher should not only give knowledge but also interest, enthusiasm, breadth of view and the ability to weigh evidence. The intern who finds in his chief a personal ideal, as well as a clinician and teacher, will remember that year of training long after his academic years have become a hazy memory. This important year may well decide whether he will retain some of his idealism throughout his professional life, or whether he will become mentally lazy and commercially acquisitive.''*

The influence of the ''chief'' who inspires his juniors is beyond calculation. ''The influence of the late Frank Billings is a case in point. Scientific honesty, kindliness, equal interest in rich or poor, absence of sham or front, an appreciation of the changed psychology of the of the sick and a whole string of equally homely virtues developed a morale far removed from the thoughts of fee splitting, commercial practice, too lofty dignity or careless work. . . . It is important that the attending man should try to get his interns' ideas and not attempt too much spoon feeding of his own knowledge; in short, the intern has a personality. He is not only present in the hospital scheme of things to be useful but he must be given power to develop.''

It is recommended:

1. THAT hospital staffs hold conferences on intern education in which officers of the Canadian Medical Association (and the Ontario Medical Association) be asked to participate.
2. THAT original articles or epitomes of papers on intern education be published in the official medical journals; and
3. THAT occasional articles or essays on the subject be included in the programs of hospital staff meetings.

2. The Interns should Receive a Proper Introduction to Their New Duties

This should be a joint effort of the intern committee, the administrator, the chiefs of services and perhaps others. The interns should be shown the buildings and the various departments; the intern committee should outline the general routine to be followed by the interns; their position in the hospital family should be explained; above all, an effort should be made to fire the young interns with the ''spirit'' of the hospital. It is advisable for the interns to meet the staff men, the superintendent, the training school staff, the supervisors, the dietitians and those other individuals with whom later they will have frequent contact.

Special attention should be paid to making the new interns familiar with the hospital *nomenclature of diseases*. Every hospital has—or should have—an official nomenclature, selected from one of the several good systems now available and this terminology should be rigidly followed in all records. Certain nomenclatures may require some preliminary explanation by the record librarian to facilitate the use of the ward guide books.

The outline of duties and responsibilities and the program of instruction are considered in the sections immediately following.

3. An Outline of Duties, Responsibilities and Privileges should be Distributed to the Interns

In addition to the preliminary talks and explanations given to the incoming interns by the members of the intern committee and others, there should be distributed to them also a printed or multigraphed outline of their duties, responsibilities and privileges. Some hospitals send these sheets or booklets to those desiring to make application for internship, thus ensuring that they have some idea of their future obligations and privileges when they make application. This would seem to be a commendable practice.

The clauses of such outline should be carefully drafted by the intern committee, working in collaboration with the administrator; if booklets or sheets have

* Rappleye, W. C., "Comments on the Internship", *J. Am. M. Ass.*, Mar. 25, 1933, Vol. 100, pp. 873-875.

* Murphy, H. H., "The Duty of the Doctor to the Hospital", *Canad. M. Ass. J.*, Oct., 1929, pp. 368-372.

already been prepared, such should be checked periodically and revised as required. The following details should be covered:

(*a*) *Rotation of Service:* If there are two or more interns, a timetable showing assignments and coverages should be drawn up. This is most important with rotating services, but is vital with straight services also. The tendency in some hospitals to rotate interns too rapidly is not to be recommended.

(*b*) *Responsibilities and Duties:* These should be clearly set forth. "Rounds" with attending doctors, history taking, clinical duties on the wards, pre- and post-operative responsibilities, operating room assignments including anæsthetics, out-patient and emergency work, reporting of complications or changes, laboratory duties, routine of obtaining consent for operation or post-mortem, are among the details which should be considered.

(*c*) *Limitation of Privileges:* Any limitations of professional initiative deemed necessary by the staff should be clearly defined; such might include prescribing of narcotics, care of emergency cases, examination of private patients, presence of nurse for examination of female patients, use of obstetrical forceps, vaginal examinations, rules covering occasions when the private physician or a staff doctor must be notified; attendance upon obstetrical patients when the intern is "contaminated" by pus contact, etc.

(*d*) *Coroner's Cases:* To avoid embarrassing situations, all interns should know on what types of cases death certificates should not be issued without the consent of the coroner. It should be clearly defined that such applies when death is due to or follows an accident, violence, suspected poisoning, suspected suicide, imprisonment, lack of qualified medical attention or abortion; when death occurs suddenly in a person apparently in good health, when the person is unidentified and possibly also when the case is undiagnosed.

(*e*) *Hours on Duty, Recreation, etc.:* The hours for attendance in ward or operating room, arrangements for going off duty and for coverage of the service, hours for meals, period for recreation and reading and hours for the use of the tennis courts and other recreational facilities should be defined. Frequency of week-end or other leave should be stated.

(*f*) *To Whom Responsible:* It should be clearly stated to whom the intern is responsible for professional direction, for discipline, and for administrative duties. The intern is in an unusual position in that, under certain circumstances, he is an employee of the hospital; in other situations he is under instructions from a visiting doctor; for some of his acts he must assume responsibility for his own actions as a graduate in medicine. (See Section F—The Legal Status of Interns, p. 57).

(*g*) *Authority:* One of the most frequently recurring sources of discontent and annoyance to the interns is to have his medical orders altered or cancelled by a ward supervisor or by a Sister in charge of a ward or by a lay hospital superintendent. If the non-professional authorities just mentioned could be made to understand that if they are not satisfied with the intern's medical orders, the doctor in attendance could very easily, without hurting the intern's feelings, alter or cancel these orders, it would not be necessary to mention this in the form. *It would, however, seem advisable to mention that the intern's authority on medical matters is under the direct supervision of the doctor in charge of the case.* This simple wording would strengthen the hand of the physician or surgeon, would give some authority to the intern and would diminish in no small degree the frequent source of heartburning and discontent.

(*h*) *Miscellaneous*: The outline might well define also such miscellaneous details as the type of service and conduct expected of the intern; ward and operating room technique, transfusion and emergency procedures, etc., relationship to the patients, the medical staff, the nursing staff, the administration and to visitors; rules respecting smoking on the wards; obtaining of and attendance at autopsies; signing of insurance and other papers; giving information or interviews to the press; collection of interns' laundry; and honoraria.

Naturally such outline should be followed with the same faithfulness which the intern would expect to give in later life. Lewellys F. Barker has well stated:

> "It is the duty of every member of the resident staff (from intern to resident) to give the best possible service of which he is capable to patients, to the professional staff and to the administrative officers of the hospital in which he works. He owes it to his hospital to be honest, temperate, diligent, thorough, courteous, modest, punctual and intelligent. Policies that have been declared and regulations that have been promulgated by the hospital authorities should be loyally supported."*

Copies of the instructions issued to their interns by a number of hospitals are in the reference library of the Department of Hospital Service of the Canadian Medical Association and may be borrowed upon request.

4. A Definite Program of Instruction should be arranged by the Medical Staff and the Administration

While the intern is in the hospital primarily, from his viewpoint, to observe and to gain practical experience, such should be supplemented by sufficient organized instruction to enable him to get the maximum benefit from his practical work. Such program of instruction will depend upon the educational background of the interns, the type of internship and the ability and attitude of the medical staff.

The Intern Committee, after considering these factors, should prepare this program of instruction. The following points are suggested.

(*a*) *Ward Rounds:* These are well worth while and every opportunity should be seized to point out and discuss interesting symptoms and signs and to emphasize many practical points in diagnosis and treatment.

(*b*) *Demonstrations:* Many hospitals arrange for demonstrations at frequent intervals. These may be as opportunity affords, such as the creation of an artificial pneumothorax, a version, eye ground examinations, the technique of handling sterile goods, gloves, etc., in the operating room and elsewhere, the technique of doing dressings, the care of instruments, the use of the oxygen tent, etc. Such may follow a definite schedule and be arranged beforehand.

(*c*) *Lectures:* While of real value, they are not as effective, on the whole, as are demonstrations. They are of most value when the interns themselves ask for a lecture on a specific subject and request some recognized authority on the medical staff to address them. Too ambitious a program is not to be recommended.

(*d*) *Laboratory Instruction:* A moderate amount of routine laboratory work should be done by the intern. This is desirable for two reasons; it gives him greater familiarity with these routine

* Barker, L. F., M.D., "How the Internship Affects the Physician's Career", *Modern Hospital*, Feb., 1931, Vol. XXXVI-2, pp. 49-53.

procedures which he should be able to do in practice and it gives him a greater interest in and knowledge of laboratory studies and their interpretation. The extent of this contact will depend to a large degree upon the inclusion or otherwise of a period of laboratory training in the internship. It will be affected also by the extent of the technical service undertaken by the laboratory staff and the setting up of special internships in pathology; nevertheless, no matter what the system, the interns on rotating or straight clinical services should be kept in close contact with the pathological and biochemical departments and be able personally to do the less complicated procedures.

(*e*) *Dietary Instruction:* Interns are appreciative of any opportunity to increase their practical knowledge of dietetics, but unless this instruction be organized, pressure of other duties usually results in the omission of this training. Members of the staff who are interested in diabetes, cardiorenal disease, gastro-enterology, etc., can discuss the various therapeutic diets; the pædiatric staff can demonstrate the different diets used in infant feeding and the preparation of such. The dietitian and her assistants can be requested to explain to the interns the various hospital diets, the preparation and handling of "special" diets, the routine established for ascertaining the daily ward requirements, the actual cooking of the food and the methods of food service. It is vital for the future staff doctor to realize the problem of dietary service, to appreciate the cost of special diets and to develop a wholesale respect for the essential routine of meal distribution.

(*f*) *Medico-Legal Involvement:* The interns should have adequate instruction concerning routine medico-legal requirements and should be warned to use the utmost care at all times lest they inadvertently involve the hospital, the medical staff, the nurses or themselves in a legal suit as a result of some alleged act of negligence or because of failure to obtain proper consent, as in the case of operative surgery or post-mortem examination. (See also Section F—"The Legal Status of Interns", p. 57).

Getting Medical Staff Co-operation

Having outlined the program of intern instruction, the intern committee must then obtain the consent of the various heads of departments and other individuals to participate in this program. This may be done by individual interview following or preceding a general discussion at a staff meeting. In one hospital in Canada a letter is sent to each staff member outlining the proposed program and asking each member to what extent he would be willing to participate in such program, the subject, hours preferred, etc., to be indicated in the reply. It should be emphasized that commitments to participate imply an obligation to continue such contribution throughout the year or the period of instruction. As a rule the response is excellent, for most doctors show themselves worthy of their title in its original sense by harbouring the pedagogic instinct. Moreover, to quote Seneca, "men, while teaching, learn"; there is no better stimulus to reading and study than the obligation to teach.

Co-operation of the Interns

Obviously the interns must indicate their appreciation of such a course by faithful attendance. All too often such courses of organized instruction are started with great enthusiasm and soon prove abortive, not because of the loss of interest of the medical staff, but because of the failure of the interns to attend the instruction. Early in the year, before the instruction be started, the intern committee should confer with the intern body and it should be clearly understood that the whole arrangement stands or falls, depending entirely upon the sustained interest and faithfulness of all concerned.

5. Adequate Facilities for the Work of the Intern should be Provided

With the increasing complexity of hospital routine, the duties and responsibilities of the intern are becoming steadily more exacting. It is advisable, therefore, that the hospital provide those facilities which will permit the intern to perform his tasks more efficiently and expeditiously.

This will depend to some extent upon the size and financial status of the hospital, but there is an irreducible minimum. If the intern be expected to do routine laboratory examinations, adequate facilities should be available and preferably there should be a clinical laboratory for interns' use close to the wards. As the intern will be expected to have completed his history and physical examination within the first twenty-four hours, the records organization should facilitate this work. Good standard forms should be provided; the record librarian should be co-operative and able to assist; larger hospitals should provide access to a dictaphone, preferably placed near the wards or the records room, or at least where the hospital stenographers could type the work dictated by the interns. In most smaller hospitals it will be necessary to write rather than dictate the histories and other records, although many hospitals are now providing a medical stenographer or ward secretary. (See also Section C-10, p. 50).

An adequate call system greatly facilitates the work of interns. Lights, silent signal numbers, the telephone and other methods are in frequent use.

Adequate quarters, restful and not overcrowded, are essential. (See Section C-22, p. 54).

6. Affiliation with nearby Sanatoria, or with Maternity, Pædiatric, Psychiatric, or Isolation Hospitals may be Advisable if such Services be Lacking

If the hospital cannot give a complete junior rotating service, certain affiliations for varying periods have been found very beneficial to the interns. While such arrangement may be somewhat inconvenient for the general hospital, there should be adequate compensation in that the service would prove more attractive to applicants. Affiliations are not necessary nor always desirable if the general hospital can give a complete rotation.

7. A Good Medical Library is Essential

"The value of a good medical library in the hospital can hardly be overestimated. Not only is it of great assistance to the intern who desires to familiarize himself with operative or clinical procedures or to refresh his knowledge of anatomy or of signs and symptoms, but it is of value to the staff members who thus have access to more scientific journals and volumes than perhaps could be purchased for one's private office, or who may desire to clarify certain operative or other procedures, frequently at a time when minutes count. A well-equipped library soon becomes a mecca for the medical staff, especially if the location be accessible, and one indirect but nevertheless quite distinct benefit of a medical library is the increased spirit of scientific interest and of camaraderie which it develops among the staff."*

A judicious balance of both monographs and journals is desirable. Individuals may favour one or the other, but each type of medical literature serves a distinct purpose. In selecting monographs and

* Suggestions for a Hospital Medical Library—booklet issued by the Department of Hospital Service of the Canadian Medical Association.

systems it is advisable to lay emphasis upon those works of a practical nature which the average intern may not have in his library. For example, in addition to loose-leaf systems in medicine, surgery and therapeutics, volumes dealing with dietetics, dermatology, venereal disease, psychiatry, psychology, neurology, forensic medicine, minor surgery, fractures, anæsthesia, and so forth, are most welcome. Year books or annuals in the various major fields are highly desirable.

The library should be under the direction of an active *Library Committee* and care should be exercised to select only those staff members whose interest in this work is known to be keen. The Chairman should be a member of the attending staff, but the committee might well include the medical registrar of the staff, the resident, if there be one, the record librarian and, particularly in smaller hospitals, the superintendent.

The *location* will depend to a large extent upon local factors, but under any circumstances the library should be in a convenient and readily accessible place. The placing of the library in the interns' quarters has often proved inadvisable because of its relative inaccessibility for the visiting staff. The best location would seem to be near the doctors' cloakroom and lounge. The arrangement is still further improved if the history and record room be included in the same suite.

The *furnishings* of the room need not be elaborate. Bound volumes are best kept in cases fitted with glass doors. Journals may be kept in pigeon holes with the current issue on display either on a central table or on a sloping top wall table at standing height with the pigeon holes below. Comfortable chairs and good illumination are required.

The *collection* of the library is a matter of local arrangement. Donations from staff members may start the library. Initial funds may be provided by the staff as a whole, by the hospital, or by both. A program for annual additions to the library should be decided upon. The library of the local medical society may be housed in the hospital. Some staff members may donate certain journals as soon as they will have read them.

The *custody* and *maintenance* of the library are the responsibility of the Committee. A *librarian* should be appointed, a common practice being to name the record clerk, who works under the general supervision of the Library Committee. All journals and volumes should be stamped upon their receipt and old copies on display should be replaced by new volumes. Arrangements should be made for the signing of a "loan record" whenever journals or books are borrowed; inventories should be made frequently. A code of *regulations* should be drawn up covering the use of the library, the borrowing of literature and the mutilation of journals and other property. These should be scrupulously respected by both interns and visiting doctors.

Further information with respect to hospital medical libraries may be obtained from booklets issued by the Department of Hospital Service of the Canadian Medical Association and by the Council on Medical Education and Hospitals of the American Medical Association.

8. Post-Mortems should be Encouraged and Conferences Arranged

Autopsies comprise one of the most effective means of teaching the intern. By such examinations he verifies the diagnoses, gauges the effects and value of treatment and broadens his knowledge of pathology. Humilility, as emphasized by Osler, is one of the great lessons of the morgue. To a large extent one may measure the scientific level of the institution and its staff by its post-mortem percentage. There are hospitals in Canada which regularly obtain over 60 per cent of autopsies and this percentage may rise into the seventies and eighties. The Committee on Internships of the Canadian Medical Association rightly agreed that no hospital would be "approved" for internship in which the autopsies did not reach at least 15 per cent.

In most hospitals it is left to the intern or resident to obtain the consent for autopsies; in one large hospital an assistant medical superintendent assumes this responsibility with considerable success. It is important, however, that each and every member of the attending staff realizes that he himself has a definite responsibility and cannot leave this to others. "Fundamentally, the necropsy percentages of any hospital depend upon the staff".* Hospitals with a large percentage of private patients have found that a high ratio of autopsies can be obtained without difficulty if the private physician or surgeon in each case will himself co-operate.

Having obtained the consent, the examination should be performed without delay and should be attended by as many as possible of both interns and attending doctors. There should be a recognized signal or a special placard which, by a selected colour or by inoffensive initials, would notify the initiated that an autopsy was about to be performed. Visiting doctors can be notified by telephone.

Clinico-pathological conferences are valuable for further discussion of the autopsy findings and the correlation of such with the clinical and laboratory data. These should be attended by the interns.

As most incoming interns have no idea how to obtain a consent for a post-mortem, some principles of approach should be discussed. Several very valuable reviews of methods of obtaining permission have been published. These include the following:

Hoffman, Wm. J., "Post-Mortem Examinations—Method of Obtaining Permission", *J. Am. M. Ass.*, Oct. 14, 1933, Vol. 101, pp. 1199-1205.

Mills, Ralph G., "Means of Securing Post-Mortem Examinations", *Bull. A.C.S.*, Dec., 1930, XIV-4, pp. 40-57.

9. Interns should be Given Greater Responsibility in the Out-Patient Department

As the conditions under which patients are investigated and treated in the Out-Patient Department approximates very closely those prevailing in general practice, the training which the intern receives in the Out-Patient Department should be considered to be one of the most valuable experiences in his hospital years. Because of this fact considerable care should be taken that the intern does receive the fullest opportunity for experience that this Department can offer.

Among the subjects or types of cases that can be closely followed in the Out-Patient Department by the interns should be included dermatology, chest cases, ambulant or follow-up diabetics, allergy cases, ambulant cardiovascular conditions, lues and acute venereal disease, cystoscopy, proctology, physiotherapy, gastro-intestinal cases, endocrinology, arthritis, dispensing and pre- and post-natal cases. An excellent outline of the intern schedule in this Department is given by Giddings and Smith in *Hospitals* (Vol. X-10, Oct., 1936, pp. 112-118).

While it is desirable to give the intern considerable responsibility in this Department, such should not be unsupervised; he would profit greatly by judicious guidance. Moreover such supervision should not be delegated to junior staff men, but should be assumed by the seniors. Sometimes it is difficult to persuade seniors to take that responsibility, but, after all, that is part of the responsibility assumed in accepting a senior honour.

* Fitz, Reginald, "Importance of Clinical-Pathologic Conferences in Work of the Practitioner as Teacher", *J. Am. M. Ass.*, July 22, 1933, Vol. 101.

10. Records and History-taking are a Vital Phase in the Education of the Intern

The taking of histories constitutes a most important element in the education of an intern. Quite apart from the value of the history as a basic part of a clinical record, with its importance to the patient on one hand and to the hospital staff on the other, every history offers the intern opportunity to improve his training in countless ways. In general, a human being sees only what he seeks; members of the medical profession are no exception to this rule. The highest ultimate efficiency of doctors entering practice necessitates an intimate as well as an extensive study of many patients suffering from a wide variety of diseases. This important and thorough experience with patients is obtained by the intern through history-taking and physical examination. In no way has he a better chance of obtaining and cultivating an understanding of the two fundamental considerations, the person and the disease, with their inter-relationship, than by patient work at the bedside, extracting a full clinical history and correlating the accompanying findings. Such activities require and exercise "pains and brains".

The natural reluctance of the medical man to do clerical work is an attitude which robs the doctor of much of his accuracy, and lessens his ability to apply much of his past experience. The formation by the intern of the "record habit" will be of inestimable value in years to come.

Clearly the importance of history-taking to each alert intern is great. However, complete responsibility for collecting and transcribing all the facts comprising a full clinical record places a heavy burden on any intern who has many demands on his time and energies. This matter may be simplified in certain ways. In any event, completeness and systematization demand use of some predetermined form, such as that generally adopted and outlined by the American College of Surgeons. The use of suitable and adequately comprehensive questionnaires in some hospitals facilitates the actual recording, as well as guaranteeing more uniformity of the resulting records where taken by different observers. In many hospitals the intern is relieved of much of the labour attached to transcription of the history by use of a dictaphone: typed copies are made later by a secretary. (See Section C-5, p. 48).

In some parts of the world, notably in the teaching hospitals in England, certain duties relating to the histories are handled entirely by students, acting as "clinical clerks". In some cases this work is assigned to special historians or nurses. It has been pointed out that these latter are responsible for noting details of all that transpires in the absence of the staff; also that they are perfectly capable of recording facts and observations as distinct from interpretations and opinions. Constant supervision can be managed by the interns, with periodic checkups by the attending doctors. Such oversight, as well as special training, is required to ensure accurate details, as opposed to the exaggerations and imaginations and faulty reasonings of many patients.

Staff men have a definite and leading rôle in regard to the work done by interns on clinical records. Upon graduation the average intern possesses a fund of knowledge and experience barely sufficient for obtaining and recording fully and clearly and in orderly fashion, the essential facts of the most straightforward conditions. He is incapable of dealing satisfactorily with difficult cases, special types, and those necessitating scientifically accurate records of graphic data, exact measurements, etc. In all such cases the intern can derive tremendous assistance from the staff man. The latter should check the history and physical findings. Whenever possible he should go over the case with the intern and give him systematic instruction regarding the significant features and their proper recordings.

The terminology of the *nomenclature of diseases* officially adopted by the hospital should be carefully followed at all times, particularly in completing records for cross-indexing.

11. Case Studies for Staff Meetings should be Prepared by the Interns

Such responsibility has distinct advantages:—

The intern will develop greater interest in the case shown;

He will be a more enthusiastic intern;

He will develop greater confidence in himself and, if permitted to present or discuss the case, he will improve his platform ability;

He will become more interested in staff meetings;

By developing greater interest in the general work on the wards, he will be a better intern and greatly increase his own knowledge;

It will bring together more closely the interns and the staff.

Much of the preparation of case studies can be left to the intern; the actual case presentation may be given in part by him.

Certain unusual case histories or findings may be suggested to the interns as particularly suitable for publication. These may be submitted for publication, either with the name of the intern associated with that of his superior, or he may be given entire responsibility for the article. An early taste for publication thus acquired may influence his entire future career.

Of particular value to the intern is the opportunity to assist his Chief or others by reviewing the literature, by making abstracts, or by preparing bibliographies. Interns could be extended reading privileges in the library of the local medical society.

12. Interns should be given Instruction in Various Nursing Procedures

While practitioners are well versed in the value or otherwise of various nursing procedures, they are frequently none too well conversant with the actual details of the preparation or method of their execution. Therefore, a real service would be rendered to the interns by an arrangement with the nursing staff whereby the interns could be given instruction in those nursing procedures which they might find it necessary to do themselves, under certain circumstances, or concerning which they might be required to instruct others.

Such might well include demonstrations in the making and application of poultices, packs, stupes, etc., the giving of enemata, hot water bottle technique, making and changing of the bed, the technique of the care of the baby, etc.

13. The Social Aspects of Medical Care should Form Part of the Intern's Experience

Medical diagnosis and treatment must take into consideration the various sociological factors affecting the patient. Medicine will make many grievous errors if it confines itself to the bedside and the laboratory. As there is a real danger that the young graduate may not fully appreciate these social factors, his timetable should include some experience in social service.

This may be accomplished in various ways. If there be a social service department, many of the arrangements can be settled through the intern. He should become familiar with the various social and philanthropic agencies in the community, ascertain how various domestic and economic crises are handled and study the social factors which might affect the diagnosis or the prognosis of his ward or dispensary

patients. In some hospitals interns visit convalescent homes, accompany the social investigator on some of her trips, go to homes for autopsy permission, follow up certain special cases or accompany the hospital ambulance. Blood transfusions may require arrangement through sources which can be reached and directed by an interested intern.

It is particularly important that the intern (*a*) become cognizant of and sympathetic towards social problems and (*b*) learn how to use available social service machinery for their alleviation.

14. Interns should have an Opportunity to Gain some General Knowledge of Roentgen Ray Interpretation and Radiotherapeutic Indications and Procedures

The following comment from Dr. H. H. Murphy, radiologist of the Provincial Royal Jubilee Hospital, Victoria, B.C., emphasizes this desideratum:

"A recent letter from Dr. Harvey Agnew, Secretary of the Department of Hospital Service of the Canadian Medical Association opens as follows:

> 'The committees on Medical Education of the Ontario Medical Association and the Canadian Medical Association in conjunction with our Department of Hosiptal Service are preparing a report on "Intern Education" . . . . among the headings which we have submitted for consideration is that of Roentgen Ray Interpretation, having in mind that in the well rounded internship the interns should be given some instruction in the Radiological Department, particularly with respect to the general interpretation of films and fluoroscopic studies.'

"The clause which I have underlined states a conclusion that is certainly long overdue. This clear cut statement of the problems is an admission of the principle—how the ideal may be materialized requires thought, enthusiasm and energy.

"In any rotating service for interns today the Department of Radiology must be considered as carefully as the surgical, medical, obstetrical and other specialized sections of the modern hospital; in other words, in assigning the individual interns to special services, the radiological department is no longer content to be given an intern when he is not occupied elsewhere. If this department is to be responsible for teaching interns then it must in return share proportionately in whatever services can be given to it by the intern staff. Granted then that one intern is assigned to the radiological service for two or three months, there will be a wealth of information for him to gain by being present during the fluoroscopic studies. He will naturally be in touch with other interns on different services and so will be able to assist in the selection of cases for discussion at the weekly review of work, which will, of course, be open to the entire staff of interns. In this way the class work will be constantly correlated with the clinical problems of the various services. The intern assigned to such service will see, even in the short period of three months, some of the definite and more dramatic results of modern radiation therapy. He will have an opportunity also to decide if his talents and interests lie in the field of Radiology.

"Only if he has decided to make this his life's work should any one be burdened with the task and expense of teaching him actual radiological technique —in which case he would naturally, at the close of his rotating service, pass on to a special period of service in the radiological department."

While Dr. Murphy here suggests that the intern should be so assigned for two or three months, such may not be possible in a twelve months' rotating service. In such instances, however, part time assignment to the radiological service should be arranged.

15. Reading Clubs and the Discussion of Current Literature should be Encouraged

Interns should be encouraged to discuss freely the cases under their care and the new literature as received in the medical library. To facilitate and organize these discussions some hospitals have formed reading clubs, Osler clubs or discussion groups. However, it is not as easy to maintain interest when these groups are formed among interns as when they are composed of staff members or of senior students. Because of the lack of continuity of personal membership, there has been some difficulty in creating fresh enthusiasm each year and it would appear that the success of these clubs *among interns* would depend largely upon the personal interest taken in such activity by one or more members of the medical staff.

Interns should be encouraged to attend meetings of the local medical society and nearby medical conventions. They cannot develop this laudatory habit too early in their careers.

16. Every Intern should be given some Insight into the Administrative Problems of Hospitals

The hospital is the doctor's workshop; much of his success and happiness depends upon the efficiency and harmonious operations of that institution. It is to be regretted that the problems of hospital administration, of hospital finance and of hospital organization are so imperfectly understood by so many doctors. Were these difficulties of financial and human relationships more fully appreciated, there would be better co-operation and teamwork, more efficient service, more confidence on the part of everybody, more economical operations and more downright happiness for the doctor.

Much can be done to give the intern this highly desirable insight into hospital administration. Early in his period of service he should be shown the non-clinical service departments—the kitchens, the laundry, the powerhouse and the stores. In many hospitals the interns have never entered these units or buildings. As a group they should have demonstrated to them the systems developed for admission of patients, accounting and general records, governmental returns, collections and social investigation. They should develop a wholesome respect for what time has proved to be really essential "red tape". They should be shown an analysis of per diem costs and the actual cost of sera, x-ray examinations, blood chemistry, etc.*

Interns should be given such instruction relative to potential medico-legal situations, so that they can be constantly on guard to protect the hospital, its staff and themselves from these entanglements.

The attitude of interns towards relatives will do much to make or break the reputation of the hospital.

As interns become familiar with the hospital routine and give evidence of ability to assume responsibility, they can be assigned certain administrative duties, such as the admission of patients, or the arrangement of transfers and, in the case of senior interns, oversight of the intern schedule. Senior interns or residents may take the employees' sick parade, including that of the nurses, may answer enquiries at night and be given general supervision of those administrative problems which are not of sufficient magnitude to warrant calling in the superintendent or his deputies. Obviously such duties should supplement, not interfere with his clinical oppor-

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* Few medical men realize, for instance, that most of our better hospitals must have more employees (excluding visiting doctors) than they have patients; that the hospital laundry list works out at between 12 and 25 pieces per patient daily; that, on the average, two-thirds to three-quarters of the patients pay less than cost, a large percentage paying nothing at all.

tunities, but it should be realized that hospital administration is now regarded as a distinct specialty field for the medical graduate and it is only by such contact that the young medical graduate with talents for administration and organization may realize the appeal of this field of service.

17. The Private Patient has a Distinct Place in the Training of the Intern

Some interns have gained the impression that attendance upon private patients does not provide as much experience as does the care of public ward patients. This viewpoint may have arisen because of the lessened privilege to examine and prescribe for such patients and the lack of opportunities to develop surgical skill. On the other hand, however, the care of the private patient offers a most valuable opportunity for acquiring the knowledge of the "art" of medicine.

The private patient is not so easy to approach as is the ward patient. The former is much more reluctant to reveal the clinical history and particularly to submit to physical examination. The private patient is inclined to be more nervous and easily upset; such patient is usually much more exacting in the details of the attention given by the nurses and doctors and much greater tact and diplomacy must be displayed in handling such individuals. Private patients are more ready to note and be critical of slovenly speech, lack of good manners and courtesy, soiled clothing or hands, omitted tonsorial attention, etc. An abrupt approach is more likely to be resented and the bedside manner must display the highest in decorum and good breeding.

18. Medical Ethics, Methods of Consultation, Proper Procedures in Coroners' Cases, etc., should be Taught by Example and by Discussion

The internship offers a golden opportunity for the intern to learn many of the essential formalities and procedures of everyday practice. This responsibility should not be left to the intern committee but should be assumed by all members of the medical staff, and instruction should be given or correct procedure pointed out and emphasized whenever occasion arises.

It is suggested that staff men should plan, as individuals, to have luncheon with the interns from time to time. With their feet under the same table and with the proper social atmosphere engendered, much can be accomplished towards driving home some of the cardinal ethical virtues which have been the traditional basis of the physician's creed. For example:

1. To the patient: honesty, conscientious service, kindliness and generosity, gentleness, cheerfulness.
2. To one's colleagues: fairness, loyalty, co-operation, assistance.
3. To one's self: honesty, confidence, with humility, zeal, personal habits, tidiness about self and office, personal dignity.

The staff doctors can do much by personal example to teach these and other principles. Moreover there must be maintained a certain dignified relationship between the attending doctors and the interns; the staff man who becomes too familiar with interns, who attempts to ingratiate himself by a convivial route rather than by that marked by confidence and respect really harms both himself and the interns.

The intern who desires to further familiarize himself with the accepted code of ethics may obtain and digest the Code of Ethics adopted by the Canadian Medical Association. He would obtain much assistance also in understanding hospital ethics by reading the excellent chapter on Ethics in "Hospital Organization and Management",* a work which should be in every hospital library.

19. Clinical and Laboratory Research should be Encouraged

The "research attitude" should be fostered in all branches of clinical medicine and surgery. New angles to clinical problems should be brought out by the Chief of the service and each intern stimulated to interest himself in some particular phase of the work. Ideas and opinions could be pooled by frequent conferences. In this way, a certain amount of healthy competition would exist and wits be kept alert.

If certain individuals show an aptitude for the conduct of clinical or laboratory investigations, such should be encouraged rather than discouraged, so long as it does not interfere with the intern's regular duties and is not prejudicial to the welfare of the patients. All work of this sort should be conducted under proper guidance and direction should be given by those qualified to do so.

Encouragement to the interns to keep informed regarding current developments in medicine stimulates the research instinct. A system of assigned reading might be applicable in some instances. (See Section C-15, p. 51, Reading Clubs).

20. An Accurate Record should be Kept of the Work of the Interns

For various reasons it is advisable to keep a record of the work and service of each intern. Such procedure permits gaps or weaknesses in the internship arrangements to be overcome, stimulates greater effort on the part of interns and is of value, and increasingly so, for future reference. As the competition for hospital and other appointments becomes more marked, increased emphasis is being laid upon the educational qualifications of the applicant. Post-graduate degrees are being more frequently sought than hitherto and for certain of these the records of the internship and other training are being scrutinized.

It is recommended that this record should contain data respecting:

(*a*) The work done by the intern, and

(*b*) His personal record.

Various methods of obtaining this information have been developed by different hospitals. The report is usually made by the intern committee, certain information being supplied by the intern himself, by the chiefs of services and by the superintendent.

One progressive Canadian hospital (Saskatoon City Hospital) has the following form filled in monthly by each intern:

Intern ..... Floor.....
Are all case reports written up?.....
How many clinics have you attended?.....
How many P.M.'s have you attended?.....
How many laboratory hours put in?.....
Have you followed your cases through the various departments whenever possible?.....
No. of operations performed.....
Major ..... Minor.....
No. of surgical assists .....
No. of surgical observations .....
No. of anæsthetics given .....
No. of obstetrical cases taken .....
No. of obstetrical assists .....
No. of obstetrical observations .....

* MacEachern, Malcolm T., "Hospital Organization and Management", p. 942, Physicians' Record Company, Chicago, 1935.

The following data respecting the intern's personal record are collected by the same hospital. This is filled in by the resident or the chairman of the intern committee:

Intern No. .....
Conduct ..... Neatness .....
Response to calls ..... Willing .....
Temperament ..... Bedside manner .....
Attitude to Discipline.....
Studious ..... Tactful .....
Special Interest .....
.....
Remarks .....
.....
Initials .....

In addition the chairman of the intern committee reports the services as a whole each month, giving the intern census, the allocations and rotations, the number of clinics, subjects and by whom conducted, and analysis of intern sickness with details and any recommendations.

The Winnipeg General Hospital rates the interns on a percentage basis calculated on the following basis:

A. PERSONAL—50 POINTS

1. Integrity (Reliability) ....
2. Initiative ....
3. Judgment and intelligence ....
4. Appearance and manner ....
5. Disposition (Willingness to co-operate)..... ....
6. Ward knowledge, including knowledge of the individual patient ....
Total ....

B. PROFESSIONAL—50 POINTS

7. Professional character (attitude towards profession—ideals, ethics) ....
8. Attitude towards patients (Courtesy and interest) ....
9. Skill in history taking ....
10. Skill in physical examination ....
11. Skill in diagnosis ....
12. Technical and manual skill ....
Total ....

Intern's Standing (total of above points).....%

The above basis on a more diversified scale is utilized by the Rochester (N.Y.) General Hospital.* Whenever a house officer completes a unit of his service, copies of this blank are mailed to all members of the staff under whom he has served. At the end of the year these reports are all consolidated on an 8½ x 11 inch card printed like the blank; on the reverse side provision is made for entering identification, date, illnesses, vacations and so forth.

ROCHESTER GENERAL HOSPITAL

REPORT OF ATTENDING STAFF FOR INTERN'S RECORD

CONFIDENTIAL INFORMATION AND OPINION CONCERNING:

Dr. ..... while serving as ..... on ..... service from ..... 192.. to ..... 192.. Date ..... 192..

NOTE.—The score indicated in parenthesis after each characteristic listed represents the maximum value which can be assigned to it. It will assist in making fair evaluations if one will recall individuals standing high in each characteristic as marked. A perfect score is represented by 100 points.

PERSONAL—50 POINTS

1. Integrity. Rectitude, honesty, truthfulness, reliability, character, loyalty ..... (10)
2. Intelligence. Mental acuity, understanding, capacity ..... (8)
3. Initiative. Energy, promptness in response.. (6)
4. Judgment and common sense. Ability to draw sound conclusions, straight thinking... (6)
5. Appearance. Personal impressiveness, care in dress ..... (4)
6. Demeanor, dignity. Reserve in manner, bearing ..... (4)
7. Disposition. Cheerfulness, good temper. Willingness to co-operate. Sense of humor, kindliness ..... (7)
8. Culture. Refinement, polish, manners ..... (5)
Total ....

PROFESSIONAL—50 POINTS

9. Professional character. Professional honesty. Attitude toward medicine. Consideration of associates, medical ideals ..... (10)
10. Skill in Diagnosis. Knowledge of medicine applied, ability to draw correct conclusions.. (8)
11. Attitude towards patients. Courtesy and kindness, consideration for their feelings, willingness to be inconvenienced in their interest, cheerfulness and self-sacrifice ..... (8)
12. Skill in History Taking. Ability to elicit relevant facts, conciseness. Painstaking care and accuracy ..... (4)
13. Ability in physical examination. Skill in various methods, systematic procedure, interpretation of findings ..... (4)
14. Technical and Manual Skill. Cleverness, in use of hands, applying dressings. Operative technique. Laboratory procedures ..... (4)
15. Meeting Emergencies. Promptness in decision. Judgment. Ability to do right thing quickly ..... (6)
16. Accuracy and Thoroughness. Quality of work. Systematic. Carefulness. Neatness.. (6)
Total ....

Remarks: Brief general estimate with explanation of any of above scores, noting all strong or weak points. This space should always be filled out most carefully.

Signature.....

The American Medical Association has a Record of Work form to be filled out by each intern. This lists a number of surgical, obstetrical, physiotherapeutic and other procedures with three columns in one or more of which the intern records the number he has (*a*) witnessed; (*b*) performed under supervision and (*c*) performed independently.

As internships become more carefully supervised and as the record of internship services becomes more important in evaluting future professional standing, it may be anticipated that these records will become more uniform in nature, for it will be essential that there be greater uniformity in the evaluation of internships.

21. Health Supervision is Imperative

More care should be taken to check the physical condition of the interns, whose long hours on duty, broken rest and exposure to infection make them just as susceptible as the nurses. Dr. Carl M. Peterson, whose work in appraising hospitals for approval for internship by the American Medical Association has given him an unusual opportunity for observation, wonders "why hospitals that exert the greatest caution in supplying regular physical examinations and standard protective tests and inoculations frequently do so for all hospital personnel except interns. . . . The record of interns breaking down with tuberculosis,

* Suggested Program for the Intern, Parnall, C. G., Proceedings Annual Congress, Medical Education and Hospitals, Feb., 1929.

to mention only the commonest offender, for lack of early detection when all facilities are available is so careless as to be almost criminal."

22. Recreational Facilities should be Adequate

The recreational side of the interns' life is frequently overlooked, yet, in view of the exacting demands made upon the interns, this should be considered an essential provision. The incidence of sickness would seem to bear some relationship to the lack of facilities for recreation. Not only is it most desirable from the viewpoint of the health of the interns but it has the added advantage that they are more readily available for special emergency calls during a greater portion of their off-duty periods.

The interns' quarters should be sufficiently isolated that the interns may feel free to relax. A radio, card tables and, if space permit, a billiard table should be provided. For outdoor recreation most hospitals provide a tennis court, one provides facilities for a hockey cushion on the tennis site, another provides season tickets to a nearby rink and another provides tickets to a nearby gymnasium.

Inasmuch as *sleep* means "recreation" in its most literal sense, every effort should be made to disturb the interns as little as possible when resting. A quiet corridor, individual rooms and a call system which does not disturb others are factors for consideration.

23. A Closer Relationship between Hospitals and Medical Schools is Desirable

There is general agreement that it would be in the best interests of all concerned if this closer relationship could be developed. All too often there is lack of continuity between the academic and the hospital training, and the intern may not only be confused but may be led to jettison many of the principles which the university has so assiduously endeavoured to instil. Medical schools with under-graduate internships can select the hospitals chosen for internships but, if the internship be not an under-graduate one, no machinery exists today for maintaining this desirable relationship. (See also section on Supervision of Internships, p. 55).

The suggestion is here made that definite steps might be taken by the medical schools and the hospitals to acquaint each other with their respective problems, desires, facilities, etc. For instance, hospitals accepting interns might notify the various medical schools regarding:

(*a*) The hospital facilities, medical organization, intern schedule, housing, honorarium, etc.;
(*b*) The type of intern desired;
(*c*) Methods adopted for the teaching of interns;
(*d*) Details wherein they found graduates of that particular school deficient.

The medical schools on the other hand could inform the hospitals:

(*a*) What supplementary or practical training would be most helpful to the interns;
(*b*) What deficiencies in the internships as provided were reported back to the medical schools;
(*c*) Detailed, possibly confidential, reports on individual students, designed to enable the hospital staff to help the intern correct any shortcomings.

24. The Woman Intern

An increasing number of women are going into medicine and, as the majority of these include an internship in their professional preparation, the attitude of the hospital towards the woman intern may be discussed. From time to time medical women's under-graduate associations have regretted that in so many hospitals internships are not available to women. An analysis of the list of hospitals in Canada approved or recommended for internship reveals that out of 712 internships available in Canadian hospitals some 60 to 70 are available for women. The number is variable because some hospitals will not take women interns unless all of the interns are women. From correspondence with the various hospitals it would appear that one of the chief difficulties has been that of providing housing for the young women. In most hospitals the employment of interns has developed to a considerable extent during the past few years and many of them are required to house their interns in quarters which are fairly crowded and which, in the first instance, were often designed for other purposes. Some hospitals meet the situation by housing the women interns in the nurses' residence or in special quarters on one of the floors.

Possibly one objection on the part of the intern committee to the employment of women interns has been a feeling that they could not adequately undertake the work regularly assigned to the interns. It may be true that for certain personal attentions to men there might be protest on the part of the male patients, particularly those on private wards. With this possible exception, the woman intern can and should be expected to perform any type of work normally assigned to a male intern. Only on this basis will many hospitals accept women interns.

In a recent editorial *Modern Hospital* has stated:

> "Prudery has no place in the life of the hospital. A woman who, through claims of modesty or physical inability, expects to avoid the performance of any medical duty does not merit either her place as an intern or the high respect which her profession should command. The intern who is a coquette is capable of seriously damaging the morale of a professional staff by her frivolty and selfishness. It is this type who prevents a more widespread adoption of women interns."

Fortunately this type is very rare in Canada, women interns having amply proved that they can successfully compete with men in holding these appointments.

25. The Honorarium

At the present time nearly all internships, with the exception of those in certain large teaching hospitals, carry some honorarium. In the case of some hospitals distant from medical schools this has been found to be necessary, as also in the case of others offering less desirable services. Some, despite a surplus of applicants, are paying an honorarium, their Boards taking the view that this is both fair and productive of better service.

There is a growing feeling that "a man is worthy of his hire". After six expensive years at college a man should be able to begin to take his place among his colleagues. While various factors will determine the size of the honorarium or salary, the minimum should be $25.00 per month with full maintenance.

Such a sum will permit of a certain degree of independence yet warrant better and more conscientious service. More than one teaching hospital pays this amount although there has been no shortage of applications, the management finding that the hospital gets a finer type of applicant and that the interns give better service.

It has been found that such a measure permits of a better control over the discipline of the intern. An increasing number of hospitals pay only part of the honorarium each month, the retained portion being paid at the end of the year and being forfeited if the intern does not complete his year or gives inferior service.

One added advantage of the basic salary would be that certain financially embarrassed graduates would be able to go to the better hospitals rather than to consider the honorarium, as some without paternal assistance must do at present.

A minimum honorarium should not seriously affect the financial status of those hospitals that may be required thereby to increase their minimum stipend.

26. A Certificate should be Awarded to those Satisfactorily Completing their Internship

This should be of modest size and might well bear the signatures of the various chiefs of services.

The question is sometimes asked, "Should there be an Honour Certificate for exceptionally satisfactory service?" Undoubtedly, some interns deserve special recognition more than others. It has been suggested that there might be a specially worded certificate issued to such individuals. This might lead to criticism, however, or to misinterpretation, as might also the statement on the certificate that First (or 2nd or 3rd) Class Honours had been awarded.

Perhaps the most satisfactory arrangement would be to issue a uniform certificate to all completing a year or more of satisfactory service and to affix a gold seal of merit on the certificates of those warranting special recognition. If impartially and not too liberally granted, this seal should be the ambition of the intern and the pride of its recipient.

Part D

Supervision of Internships

At the present time while internships are supervised, the work of those interns who are graduates is not checked except for the supervision exercised by the local hospitals and its committees. This statement may require explanation.

Until 1931 no supervision or grading of internships in Canada was attempted except insofar as a few individual hospitals applied for recognition by the Council on Medical Education and Hospitals of the American Medical Association; nine were so listed. At that time the Department of Hospital Service of the Canadian Medical Association undertook the drafting of a Basis of Approval and the setting up of an approved list of internships in Canada. This Basis of Approval sets a high standard; requiring a well organized and scientific staff, adequate facilities and equipment, 15 per cent of autopsies, a library, sympathetic oversight, sufficient clinical opportunities, etc. Most helpful assistance was furnished by the American Medical Association and reciprocal recognition of the respective lists was arranged. Each year more hospitals have met the requirements set forth in the Basis of Approval until now there are in Canada 43 "approved" hospitals representing some 674 internships (excluding residencies). To this list should be added 19 "recommended" hospitals with 59 internships; these are hospitals which do not entirely meet all the requirements for full approval but which nevertheless offer the young graduates excellent opportunities for internship. It is to be noted that this supervision is of the *internship* and not of the *intern*.

Increasing Unrest Noted

Internships in Canada have never been so highly organized and so valuable as they are at the present time. Yet there is more unrest among certain interns today than ever before. Reports are being received with alarming frequency of dissatisfaction and discontent. Long alternate week-ends are being demanded without consideration of the needs of the patients; strikes have occurred for higher pay; assigned duties have not been performed; interns have absented themselves from duty without permission and even against orders. While some interns are unceasing in their faithful devotion to duty, others do the minimum of work. It is an all too common occurrence for interns to pack up and leave almost without notice whenever a likely opening in practice presents itself. Contracts are quite ignored. Of particular concern to hospital workers has been the lack of respect for professional ethics on the part of some intern.

It should be added, of course, that such offenders constitute the minority. The great majority of interns, as in years gone by, are most conscientious in their work and faithful to their responsibilities. The minority, however, can and do effect a lot of dissatisfaction and can quickly disrupt a service and destroy its morale. Administrators are concerned because of the ever present danger of malpractice suits should an omission of duty or act of negligence occur.

This situation does not exist to anything like the same degree where the interns are still under-graduates. The fact that their degree depends to some extent upon the report of their work sent to the medical school has a most stimulating effect.

Causes—Including Shortage of Interns

Much of this unrest may be due to the "spirit of the times". Some of it may be augmented by the realization that the internship is not really obligatory, a contract may be broken without prejudice to one's future career and that one can go to some other hospital for the balance of the year. There are now over one hundred more approved internships in Canada than there are men and women to fill them. Each year sees more unfilled posts, since the number of approved and recommended internships is steadily increasing, while the output of graduates remains relatively constant.

Sometimes, too, the hospital or its medical staff may not be sufficiently "intern-minded". Interns may be engaged without a realization that, from their viewpoint, they are there primarily to learn, and that the balance of "duties" and "privileges" should be fair to both sides. Some interns of a serious nature seeking knowledge have been fed stones instead of fish. It is hard, however, to conceive of this occurring to any serious extent in a hospital "approved" for internship.

Some Supervision Required

Because of this varying degree of efficiency with which internship duties are undertaken and because of the frequent lack of respect for contractual obligations and, of extreme importance, for the resultant welfare of the sick, it is obvious that some form of supervisory control over the internship is desirable. This would apply particularly to the first year of internship. Those graduates going on to senior appointments and residencies usually take their responsibilities and opportunities very seriously, but here also a high standard of conscientious service should be exacted if such training is to be cited or utilized in qualifying for special appointments, certificates or degrees.

However, such supervisory control should be vested in some body able to enforce its stipulations. As already referred to, the Department of Hospital Service of the Canadian Medical Association has a high standard of qualification for the approval of hospitals for internship and has assisted in the development of exceedingly fine internships, but it has no supervisory power over the quality of the work of the intern, nor can it take any action should an intern decide to break his contract or refuse to subscribe to hospital and staff rules and regulations. Such have been repeatedly flouted with relative impunity, for, beyond dismissal or the withholding of a certificate or the terminal honorarium, the hospital intern committee has had no means of impressing upon such individuals that irresponsible actions cannot be permitted. What bodies could conduct this supervisory control? It would appear that the only two types of organizations or bodies which could do this satisfactorily are:

(*a*) The medical schools;
(*b*) The licensing bodies.

(a) Supervision by the Medical Schools

The simplest form of such supervisory control would be by the establishment of the *under-graduate internship*. Such are now found in a number of Canadian and other medical schools. Under-graduate internship has been in operation for some years in Dalhousie University, Université de Montreal and University of Manitoba. Quite recently this arrangement was adopted by McGill University. Final year men "live in" to a varying extent in l'Université Laval, Queen's University and the University of Alberta, but this is not obligatory and is limited to a portion of the graduating class only. In the United States the degree is not granted until after a period of internship in the University of Minnesota,* Stanford University, Rush Medical College (University of Chicago), Northwestern University, Loyola, Cincinnati, Southern California and a number of other medical schools—some fifteen in all.

Undoubtedly such arrangement would permit a much closer check both on the quality of the internships offered and upon the service given by the interns themselves. Interns would probably get more out of their internships than under the other system in which the internship is considered to some extent as a period of relaxation from the vigilant oversight and impending examinations of the under-graduate years. Moreover hospitals and their staffs would be more closely linked with the medical schools and this would mean added incentive to teach and maintain a high level of efficiency.

Some possible disadvantages can be envisioned. A few members of graduating classes may be working towards a research or laboratory career and may not be interested in clinical experience. For those a laboratory or other alternative may be optional, as under the new arrangement at McGill University. There would be a tendency also for hospitals not affiliated with medical schools to have added difficulties in completing their complement. As the better of these hospitals would probably be recognized for under-graduate internship, and as many non-teaching hospitals have considerable trouble now anyway in getting sufficient interns, added difficulty would probably be relatively small.

Under-graduate interns, of course, cannot be licensed; this would require that the limitation of their legal responsibilities be recognized and allowed for, as is now done where such interns are employed.

(b) Internship Required for Licensure

The other alternative is the requirement that at least one year of internship be satisfactorily completed before the license to practise be granted. This would seem highly desirable, for the individual who desires to enter practice and who has not had an internship cannot but be handicapped in his later clinical life. Moreover the patient has the right to demand adequate clinical as well as theoretical knowledge in the young licentiate. Also, with an increasing number of the recent graduates taking two, three and more years of post-graduate training, the practitioner of the next generation without this background is going to find it increasingly difficult to hold his own in an ever-tightening competitive field.

At the present time internship experience is not required for licensure in any province in Canada. The requirements of the Medical Council of Canada are governed to a considerable degree by the standards set by the provincial licensing bodies, for "the standard of examination shall not, at any time, be lower than the highest standard for the like purpose then established for ascertaining the qualification for registration in any province". Hence there has been no obligation to set up an internship requirement in the Dominion body.

In many respects our standards of education and qualification, based as they are upon British tradition, have emphasized academic rather than practical preparation. Across the border increased emphasis has been placed upon practical training. The National Board of Medical Examiners, whose certificate is now recognized in forty-three states, required "completion of a contract of at least one year in an acceptable hospital as an intern, or a year in an acceptable laboratory". For individual state qualification, internship is required in nineteen states.

It is doubtful if this arrangement would inflict any particular hardship upon the members of the graduating classes. Few indeed of the graduates of the past five or ten years have gone directly into practice without an internship. Several provincial Registrars have reported that for some years practically no men have been registered who have not had internships. The Report of the Commission on Medical Education stated that "over 95 per cent of all graduates from schools which do not require the internship for graduation take a hospital experience of at least one year". The percentage has probably risen in the intervening five years and, of the dwindling minority left, most can be accounted for by those who go into laboratory or research work, or into public health, who leave medicine entirely, or go abroad for post-graduate study. Many of these will never apply for a license to practice. Obviously the step from a voluntary to an obligatory internship would be much less of a possible handicap or hardship than was the addition of another year to the course on two previous occasions. While there is no desire to add to the economic burdens of the recent graduate, the cost of taking an internship with full maintenance and frequently an honorarium is usually less than that of attempting to set up a practice.

One advantage of this arrangement would be that it would ensure clinical experience on the part of those from other countries who apply for licensure. As there is now reciprocal recognition of approved internship lists as prepared by the Canadian Medical Association and the American Medical Association, internships in approved hospitals in either country could be recognized for credit by licensing bodies in the alternate country. Similar arrangements with Great Britain would depend to a large extent upon the future evolution of our systems of medical education.

Another advantage is that more of the interns would be graduates, having some legal responsibility for their medical actions. If desired, to such interns an "interim certificate" to practise, tenable only during their internship period, might be authorized.

An exception may be desired for those who wish to practise in partnership with, or as an assistant to, a senior colleague in lieu of internship. This might be favourably considered, although in very few of such assistantships could the experience equal that possible in an active internship.

With the adoption of this internship requirement, the final decision concerning the acceptance of a submitted record of internship would rest with the provincial licensing body or with the Medical Council of Canada, depending upon whether the internship be required in order to take the examinations or be required only for actual licensure in the various provinces. Most recent graduates prefer to take the Medical Council of Canada examinations immediately upon graduation. This could be done as at present, but the provincial College would not grant the license to practise until the internship be completed. Should an accredited internship be required for the Medical Council of Canada diploma, it might be desirable to

* A full description of the various questionnaires, reports, form letters, etc., used by the University of Minnesota in supervising under-graduate internships is given by Dr. J. C. Litzenberg in the *Journal of the Association of American Medical Colleges*, July, 1934, IX-4, pp. 216-224.

permit the written examinations immediately upon graduation and give a more practical oral examination at the end of one year. Or, if preferred, the examinations could be held as at present and the diploma withheld until the satisfactory completion of the internship year or an equivalent period of laboratory training. If by-laws would permit, the simplest arrangement would seem to be to make internship necessary for provincial licensure only, and not for Dominion certification.

Reports Required

Under either alternative proposal, the undergraduate internship or the conditional license to practise, the supervising body would require adequate reports both upon the facilities and oversight offered by the various hospitals and upon the record of the individual intern. The former could be achieved with the co-operation of the machinery already set up by the Canadian Medical Association, but the latter would require that reports be sent directly to the medical school or the licensing body affected.

Recommendation

In view of these various considerations, it is the opinion of this joint committee that:

1. Recent graduates in medicine would profit greatly if during their internship period their work could be under more supervisory control than is possible at present.
2. Such supervision could be best effected by requiring the internship year for either (*a*) the academic degree of the medical school, or (*b*) the license to practise.
3. Of these two alternatives it is the opinion of this Joint Committee that, while either of these alternatives could affect the supervisory control desired, the requirement of an accredited year of internship in order to obtain a license to practise would achieve this result with a minimum of re-organization.

NOTE.—At the joint meeting of the C.M.A. and O.M.A. in Ottawa, a meeting is being arranged at which representatives of the medical schools, the Medical Council of Canada, the provincial licensing bodies, the Royal College of Physicians and Surgeons of Canada and organized medicine will discuss this question.

The Joint Committee has been in correspondence with the various licensing bodies and through the members of the C.M.A. Committee on Medical Education with the medical schools of Canada. These comments will be reviewed in the final printing.

Part E

Residencies in Specialties

There is a growing need for more residencies in specialties. As the standards of qualification for the practice of medicine rise and competition increases, more of our younger graduates are desirous of taking advanced work in their chosen fields. Moreover a number of the higher degrees and memberships now require extensive training in their respective specialties and it is frequently a problem for the young aspirant to know where he can get the required training. This is exemplified in the recent regulations requiring high minimum standards of training for the various specialty bodies in the United States approved by the Advisory Board of Medical Specialties. At the present time only a limited number of residencies provide the educational features now insisted upon.

The changing basis of medical practice is increasing this demand for special training. The possible advent of widespread health insurance has focussed attention upon the necessity of developing some sort of certification for those desiring to practise as specialists. At the 1936 annual meeting of the Royal College of Physicians and Surgeons of Canada, in his Presidential Address, Dr. A. T. Bazin stated:

"With the advent of statutory bodies setting up schedules of fees for medical services rendered (Workmen's Compensation Boards, Health Insurance Commissions, etc.) it is becoming more and more evident that there should be established an authoritative register of qualified specialists.

"In Great Britain this responsibility is undertaken to some extent by joint action of the Royal College of Physicians of London and the Royal College of Surgeons of England. . . . Your Council has secured legal opinion as to what amendments to your Charter are necessary to empower this College to set up standards (of educational qualification, of clinical and practical experience and of examination) to meet the situation.

"Your Council meeting this forenoon resolved that the College shall enter upon this responsibility and machinery has been established toward that end. . . ."

Residencies Not Now Approved in Canada

While the Canadian Medical Association approves hospitals for junior and senior internship, such approval does not extend to residencies. These latter are compiled in a list made available to enquirers, but not bearing any formal imprimatur of approval. The American Medical Association does approve residencies in the United States utilizing for this purpose an excellent basis of approval.

In the light of present trends, it would seem desirable that,

(*a*) More residencies be established, and

(*b*) Residencies be "approved".

A number of very fine residencies are now maintained in some of our larger hospitals and this number might be increased. There is, of course, a limit, for a residency loses its attractiveness if the experience be too limited, if the medical staff be not so organized that there is a place for a resident, and if there be a lack or dearth of instruction. In view of the growing desire to lay greater emphasis upon the basic sciences, especially anatomy, physiology and biochemistry, some linkup with a medical college is distinctly advantageous.

Approval of such residencies might be undertaken by the Canadian Medical Association, through its Department of Hospital Service, and with the co-operation of the Royal College of Physicians and Surgeons of Canada and the various medical colleges. At the present time the number of residencies which would be able to fully meet the requirements likely to be set up would be comparatively small, but, as in the case of the approval of junior and senior internships, it would be reasonable to anticipate that the number of approved residencies in specialties would increase as time goes on.

Part F

The Legal Status of Interns

The legal status of the intern depends upon several factors and, therefore, cannot be crystallized into a simple statement. It is unfortunate that the importance of these various factors is not always fully realized by the interns and those whom they serve.

Unless the hospital intern holds a license to practise in that particular province, he has no legal status as a physician and therefore cannot legally sign death certificates, prescribe narcotics or fill in and sign certificates for such bodies as the Workmen's Compensation Board. He cannot practise medicine in his own right and must perform the above duties only as the deputy of a legally qualified practitioner who, of course, would to a varying degree be considered responsible for such actions (vide infra). The fact that the Dominion Medical Council had been "taken" would not constitute legal recognition, as such certificate in itself is not a license to practise, although

such qualification undoubtedly would be taken into consideration by the courts.

Where the intern is licensed to practise in the province where the hospital is located, he would have the same legal status as would a physician in practice.

In some provinces the College of Physicians and Surgeons does notify hospitals that interns should be registered and licensed in that particular province. Obviously this could not apply to those interns whose internship is being taken prior to graduation as required by certain medical schools. It has frequently been urged that an "interim certificate" should be available for those hospital interns who may desire to take internship in a certain hospital, but who are preparing to practise in another province or in another country. With the increasing recognition of the value of internship in Canadian hospitals and the creation of desirable residencies, this matter must be given serious consideration.

In other provinces registration and licensure are not required as it is considered that the intern is still a student and is not earning his livelihood by practising medicine.

Factors Affecting Status

If the intern be involved in legal action, several factors might influence the interpretation of his position:

(*a*) Whether or not he has a license to practise;
(*b*) Performance of the action in question as a "servant" of the hospital;
(*c*) Performance of the action as a "servant" of the practitioner in charge of the case;
(*d*) Personal liability for his own action. Acting as an "independent contractor".

Legal decisions defining the position of nurses are much more frequent than those relating to interns, but a major factor in most cases would seem to be that of whether the nurse or intern was acting as the "servant" of a member of the medical staff, as the "servant" of the hospital, or exercising his own skill and judgment as a physician. As the intern is actually an employee of the hospital, the fundamentally recognized "master and servant" may sometimes dominate the situation. This is by no means necessarily so, however, for, as stated in a recent Appeal Court decision, "The hospital is not responsible for negligence on the part of the medical staff including the houseman or interns when they are acting in a professional as distinguished from an administrative capacity."*

After reviewing the basically important cases of Hillyer *v.* St. Bartholomew's Hospital, Lavere *v.* Smith's Falls Public Hospital, Nyberg *v.* Provost Municipal Hospital and others, Mr. Rowell, C.J.O. in the above case states:

". . . . the following legal propositions appear to me to be established:—

1. That the responsibility of the hospital authorities is limited to undertaking that the patient shall be treated only by experts, whether surgeons, physicians or nurses, of whose professional competence the authorities have taken reasonable care to assure themselves, and, further, that these experts shall have at their disposal for the care and treatment of the patient, fit and proper apparatus and appliances.
2. That the hospital is not responsible to patients for mistakes in medical treatment or in nursing on the part of its professional staff of doctors or nurses of whose professional skill it has so assured itself, nor for the negligent use by them of the apparatus or appliances which are at their disposal.
3. That the hospital is responsible to the patient for the due performance by the members of its professional staff within the hospital of their purely ministerial or administrative duties."

Under certain circumstances the intern is acting as the agent or servant of the staff doctor. For instance in Hillyer *vs.* the Governors of St. Bartholomew's Hospital the decision with reference to nurses and carriers might well refer to the interns (1909, 25, TLR, 762):

> "But although they are such servants (of the hospital) for general purposes, they are not so for the purpose of operations and examinations by medical officers. If and so long as they are bound to obey the orders of the defendants, it may well be that they are their servants, but as soon as the door of the theatre or operating room has closed on them for the purpose of an operation (in which term I include examination by the surgeon) they cease to be under the orders of the defendant and are at the disposal and under the sole orders of the operating surgeon until the whole operation has been completely finished; the surgeon is for the time being supreme. . . . The nurses and carriers, therefore, assisting at an operation, cease for the time being to be the servants of the defendant, inasmuch as they take their orders during that period from the operating surgeon alone and not from the hospital authorities."

A significant United States decision refers directly to the status of the intern and this decision has been cited with approval in the English, Scottish, New Zealand and Canadian courts. (Glavin *v.* Rhode Island Hospital, 34 Amer. p. 675).

> "There are some cases of minor importance in which the interns are allowed to act as physicians and surgeons, and in such cases I think that their relation to the corporation does not differ from that of a visiting physician or surgeon. But the interns act in still another capacity. The corporation undertakes to furnish physicians and surgeons for all kinds of cases, including the most critical. It has a regular staff of physicians and surgeons. But inasmuch as these are not, like the interns, constantly in attendance at the hospital, they must frequently be sent for. The corporation undertakes to send for them, and, of course, it must do it through an agent. The interns are the persons appointed to perform this duty for it. A rule of the hospital prescribes that in all cases requiring immediate and important action, in all doubtful cases, and in all cases requiring an immediate operation, the intern shall send for the surgeon of the day, and if he cannot be found, for one of the other surgeons. Here then we have the relationship of principal and agent, or master and servant. If the intern neglects to call the surgeon in the class of case designated, his neglect is the neglect of the corporation."

The following statement of law is from Corpus Juris:

> "A hospital which has exercised due care in selecting its professional staff is not liable for any injury caused by the negligence or tortuous act of a member of such staff occurring during the course of his professional duties, at least in the absence of special contract. And the rule has been held to apply to the negligent or tortuous acts of physicians, resident physicians and surgeons."

Legal Protection of Intern

Because of the increasing habit of the public to seek redress in the courts for possible or fancied injury, legal protection for the intern is indicated. As interns give the hospital considerable service and as they are not in a financial position to provide their

* Masten, J. A., Vuchar *vs.* Toronto General Hospital, Ontario Court of Appeal, Dec. 4, 1936.

own protection, there is a strong feeling that this should be provided, should occasion arise, by the hospital.

In addition to policies issued by liability insurance companies, protection is available through the Canadian Medical Protective Association which renders an invaluable service to its members at a very reasonable rate. It might be possible to prevail upon this organization to so revise its by-laws that interns, not "duly licensed" would be eligible for membership.

Part G

The Intern Committee

The intern committee is one of the most important of all staff committees. Its personnel should be carefully selected, for on it depends to a large extent the efficiency and smoothness of the intern arrangements. The intern committee should be composed of men who have been interns themselves and know the interns' problems; who are keenly interested in the welfare of the interns and are prepared to give them freely of their help; who feel a responsibility for the future of the interns and are prepared to insist upon a high degree of efficiency and service. The chairman, particularly, should be one who is willing to take a fatherly interest in the interns, who can be approached without hesitation, who has sufficient influence to uphold the rights of the interns, but who does not hesitate to talk like a "Dutch uncle" when the occasion so warrants.

The intern committee should be appointed by the medical staff and should hold office for one year, with the privilege of re-appointment.

Of particular importance, every intern committee should make sure, first of all that its own members are thoroughly in sympathy with the underlying principles of intern education. An uninterested, unsympathetic and uninspired intern committee can do very little to create an enthusiastic, highly efficient, intern body.

Appointment of Interns

In addition to the many responsibilities outlined in the preceding pages, the intern committee is usually charged with that of the selection of interns.

Most Canadian hospitals select their interns on the basis of appointment rather than by examination. There is no uniformity in the types of application forms used. Intern committees usually select their appointees on the basis of (*a*) scholastic attainment; (*b*) special interest in certain work, as in the case of straight services or residencies, and (*c*) personal qualifications. These last are usually determined or estimated by personal interview, when possible, and by enquiry. Some hospitals with university affiliations are expected to give preference to their own graduates; other hospitals make it a point to diversify the schools represented, thus broadening the background and views of the intern group.

It is recommended that:

1. The hospital staffs take special pains in the selection of the intern committee;
2. The hospitals develop a uniform type of application form. This could be arranged through the Department of Hospital Service of the Canadian Medical Association.
3. The hospitals make appointments at approximately the same date, *e.g.*, the first of December, January or February.

The dates now vary between October and May. This recommendation is urged because there has been considerable dissatisfaction over the fact that a final year student will be accepted by one hospital, say in November, and in March that hospital will be notified that the appointee is going to some other hospital by which his application will have just been accepted. Applicants will desire, naturally, to apply to several hospitals and the situation would be simplified considerably if all appointments were announced practically simultaneously. Candidates successful in two or more applications would then immediately make their choice and the other hospital(s) could communicate with other applicants. With co-operation the whole graduating class could be placed within two or three weeks.*

This report was discussed in four sections, as follows:

1. Why medical students in Great Britain are qualified to enter the practice of medicine at an earlier age than students in Canada.

This section was approved.

2. The application of sound physiological principles in the teaching of therapeutics.

This section was approved.

3. The abolition of dual examinations, *i.e.*, first for a degree and, second, for license to practise.

This section of the report was referred back to the Committee for further study.

4. A study of Intern Education and Supervision.

This section of the report was referred back to the Committee for further study.

REPORT OF THE COMMITTEE ON MATERNAL WELFARE

Mr. Chairman and Members of the General Council:—

I have the honour to submit the following report of the Maternal Welfare Committee for the year 1936-37:—

The maternal mortality rate in Canada during the past year has shown the usual variations in different localities. The main causes of maternal death remain the same.

This year your Committee has endeavoured to follow up the recommendations made last year with the result that one sub-committee has drawn up a guiding minimum standard for hospital obstetrical facilities and rules governing maternity service in the larger organized hospital; a second sub-committee is doing the same for the smaller rural hospital. These reports, when complete, should be practical in their recommendations and suitable for all Canadian hospitals. As presented to Council these reports will be still open to further revision before final distribution. Should these standards receive your endorsation, it is suggested that they be forwarded to the Canadian Hospital Council where, we have been assured, they will be favourably received and an effort made to get them accepted by its members.

It would appear that the Federal Department of Pensions and National Health is interested in our problems. They have suggested that a Committee of the Dominion Council of Health be appointed to report on the question of maternal demonstration areas. This Committee has been appointed and has met, and we believe, intends to report back in June to the effect that a fresh study should be undertaken preferably by a detailed survey of all births occurring during one year in one of the provinces. Your Committee has been active in helping to draw up a suitable questionnaire for such a survey. Should such a survey be made, your Committee feels that our efforts to eliminate preventable maternal deaths will be on a much sounder basis.

During the year at least one Faculty of Medicine has put on a refresher course in Obstetrics, for its graduates.

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* Dr. F. C. Zapffe, Secretary of the Association of American Medical Colleges, to which several Canadian medical school belong, has evolved a system whereby this body through a Bureau would receive applications and assign interns to the various hospitals.

As the rôle of Obstetrics in the scheme of preventive medicine becomes more and more apparent each year, your Committee feels that the teaching of Obstetrics to undergraduates in our Canadian schools should receive the earnest consideration of all interested in the health of Canadian youth and womanhood.

All of which is respectfully submitted.

J. D. McQUEEN,
Chairman.

Approved.

OBSTETRICAL PROCEDURES AND PRACTICE IN HOSPITALS

Prepared by the Committee on Maternal Welfare of the Canadian Medical Association

INTRODUCTION

If there is to be any further reduction in maternal mortality—and further reduction is most desirable—such can be accomplished only by a searching analysis of *all* of the factors which may contribute to the sum total of maternal and fetal deaths. While there are many major factors which are beyond the control of the obstetrician or the hospital, such as geographical isolation, metabolic, cardiac, structural or other weaknesses or deficiencies on the part of the mother, abnormal fetal positions or development, lack of cooperation on the part of the patient, and so forth, nevertheless there are factors in obstetrical morbidity and mortality the control of which is definitely in the hands of the doctors and the hospitals which they attend.

As an increasing number of obstetrical patients is being cared for in hospital, the Committee on Maternal Welfare of the Canadian Medical Association is convinced that one obstacle to the reduction of maternal deaths can be overcome if all hospitals accepting obstetrical patients agree to set up a standard of organization and care at least equal to that outlined in this report. Most of our hospitals, particularly the larger ones, now have well organized obstetrical departments, but it would appear that in all too many institutions much still remains to be developed in the way of organization and supervision and in providing adequate facilities to meet emergencies and prevent cross-infection.

Obviously certain features herein recommended, particularly with respect to staff organization, nursing technique, and the isolation of the maternity department, cannot be applied unaltered to the many small hospitals of 10 to 40 beds throughout the country; also, in many hospitals located in towns or in the smaller cities, it is a common arrangement that all patients, whether paying or not, be considered as private patients, there may be no outpatient clinics and no social service. In such instances certain modifications or simplification may be necessary; any lowering of these recommended minimum standards, however, should be only that which the size of the hospital and the dearth of assistants and facilities render absolutely necessary.

For those hospitals of approximately twenty-five beds or less, Part II of this report has been prepared. It is especially written to meet the situation where there are very few doctors, or a doctor may be working single handed, when equipment and isolation facilities are minimal and where the few nurses must be "Janes-of-all-trades". In such instances, even though procedures must often be a reluctant compromise, every effort should be made to maintain a standard as high as is humanly possible.

The Committee gratefully acknowledges the help received from the manual of the American Hospital Association on this subject, portions of which have been adopted *in toto* and the Report on Hospital Standardization of the American College of Surgeons.

The problems involved are discussed under the following headings:—

PART I.
OBSTETRICAL PRACTICE IN LARGE OR WELL ORGANIZED HOSPITALS

1. Accommodation
2. Clinical Facilities
3. Organization of the Department
4. Clinical Records
5. Staff Conferences
6. Procedures
7. Care of the Newborn
8. Extra-mural Services

PART II.
OBSTETRICAL PRACTICE IN SMALL HOSPITALS

9. Accommodation, Equipment and Facilities
10. Obstetrical Technique in a Small Hospital
11. The Small Hospital and the Physician

In the addenda (to be included in the reprints) will be found suggested equipment, schedules, obstetrical routine and visiting rules.

PART I.—OBSTETRICAL PRACTICE IN LARGE OR WELL ORGANIZED HOSPITALS

PURPOSE

The endeavour that organized medicine is making to lower maternal mortality and morbidity places a special responsibility on the hospital. If it is to play its part in the modern crusade, it must abandon certain traditional characteristics and conform to a high standard demanded by modern knowledge. Perhaps, the ideal organization is unattainable, but the effort is made in this manual to outline a practicable standard to which each hospital should conform.

It is not the function of this report to discuss the relative merits of hospital care as contrasted with home care. It is the view of the Committee that hospital care, raised to a proper standard, brings increased safety to the patient and that it should be obligatory on all hospital organizations to reach this standard.

The inefficient hospital ambushes its patients with two sinister dangers: The first is cross-infection and is the inevitable hazard where the hospital organization does not ensure the complete isolation of each patient from the other and the immediate segregation of all cases of pyrexia. The other danger appears when the convenience of hospital equipment encourages injudicious interference and needlessly radical procedures. The hospital must undertake to protect the patient from both of these disadvantages and can do so with efficient organization.

The special advantages that a hospital can bring to the patient are many. These include the greater flexibility of treatment which hospital equipment provides for abnormal conditions, the benefits of the puerperium conducted away from the disturbing factors of a domestic environment, the facility with which diagnostic difficulties can be solved, and the promptness with which emergencies can be dealt. These are factors the value of which will meet with universal agreement. Not the least advantage of efficient hospital routine is the fact that it is more practicable to apply a safe conservatism in the obstetrical wards than it is in the home, where the anxiety of friends and relatives may often result in inducing the attendant to undertake premature and meddlesome interference. A properly organized obstetrical hospital unit is the ideal place for a woman to have a baby. Naturally the hospital tends to have its mortality raised because of receiving and caring for abnormal patients, but any one, familiar with the problem of maintaining good obstetrical technique in a home with limited facilities and untrained assistants, knows full well what lessened chances such patients would have without the special advantages which hospitals can provide.

SECTION 1.—ACCOMMODATION

The hospital should offer the usually recognized types of obstetrical accommodation; these can be classified as general and special.

General

(*a*) Private rooms for the well-to-do or those who can pay their way. There is nothing special to be mentioned regarding private room accommodation for obstetrical patients. So far as possible, however, ample provision should be made for lavatory and toilet facilities. The ready availability of running water for washing of hands is desirable. Provision for individualized technique should also be made.

(*b*) Semi-private rooms or wards for the patient of moderate means or those who cannot afford to pay the full charges of a private room. For this purpose rooms with two beds are necessary, affording adequate space and screening between beds so as to give more privacy to each patient. Such patients usually pay a moderate fee to their attending physician.

(*c*) Public wards of four to six beds for patients who can pay only in part or who cannot pay anything towards their hospitalization. Provision should be made for the screening of patients one from the other with curtain screens, wooden, part translucent glass or metal partitions, extending six to six and one-half feet high and six inches from the floor, forming a cubicle arrangement. Each patient in a public ward should be as much segregated from other patients as possible so as to permit individualization of technique. This includes the segregation of utensils used by individual patients so that each has her own bed pan, thermometer, treatment tray, etc.

Special

Of a more special and important nature is the making of provisions for the isolation of such cases as develop temperature or other evidences of infection. In the absence of a properly arranged isolation unit, the infected patient should be removed from the obstetrical ward to some other accommodation in the hospital, preferably to the medical section where there are no open surgical wounds. Extreme care should always be exercised in segregating such cases from gynæcological or surgical cases because of the danger of cross infection. A better method would be to remove these cases to a completely segregated section.

At least one bed in the segregated area for every ten to twelve obstetrical beds should be provided. In this unit the patients should be strictly isolated one from the other in cubicles or preferably in single rooms, each of such being provided with running water and the other individual facilities required. Separate provision should be made for a ward kitchen, and lavatory, bathing, and treatment facilities so that none of these services will have to be drawn from other parts of the hospital, and thus perhaps open up avenues of infection.

It is important that infected babies be removed immediately from the clean nursery. Therefore, there is need for a nursery in which to isolate babies showing skin rashes or infection of any kind. An isolation nursery with cubicles should be arranged in a convenient location. If strictly isolated, it can be on the same floor as the general nursery, but it should be self-contained, having its full range of facilities so that the child can be taken care of without using the facilities from the general nursery. Here, too, facilities and supplies for individual technique in each cubicle should be provided.

SECTION 2.—CLINICAL FACILITIES

In addition to the ward accommodation, provision should be made in the obstetrical department for the following units; preparation room, service rooms, predelivery or labour room, birth or delivery room, and nursery, as well as the use of such adjunct facilities as clinical laboratory, x-ray, etc. With the exception of the clinical laboratory, x-ray, and such facilities of this nature as are necessary, the other units should be part of the obstetrical department located in a convenient but segregated area.

Preparation Room

The preparation room should be of convenient size to handle one patient at a time, unless the service is more than 25 beds, when additional space by cubicular or other means should be provided for each additional 50 beds. In this room there should be facilities for carrying out all the procedures in connection with the preparation of the patient, such as a shower for cleansing the patient, wash basin, examining table, facilities for giving an enema, and the necessary preparation tray. This room should be near but outside the entrance to the ward. A locker is desirable for the keeping of clothes prior to proper listing and storing away under the regular hospital system. Provision should be made for a preparation room record indicating condition of patient on arrival and what was done to the patient while in this room.

Utility or Service Rooms

Service rooms are required in connection with the wards and labour rooms, but should be physically separate from them. Such service rooms can be equipped in the usual standard fashion, but in the case of the service room attached to the birth rooms it is necessary that there be much increased sterilizing facilities because of the greater demand for the sterilization of utensils and supplies in the delivery or birth room suite.

Predelivery Room

The predelivery room, or labour room as it is sometimes called, is that in which the patient remains during the first stage of labour or, in other words, from the time the pains commence until the patient is ready for delivery. This room should be in close proximity to the birth or delivery room; in fact, it should be interconnecting. Here also space should be allotted, one bed for every 25 patients or fraction thereof. The labour or predelivery room should contain merely the ordinary furniture of any hospital room, that is, bed, bedside table and chair, but should have a good extension light so that the patient can be properly examined by the doctor or nurse when necessary. Such a room should be well sound-proofed because there will be more noise here than in any other part of the hospital. It is also highly desirable that the room be provided with toilet and lavatory facilities.

Delivery or Birth Room

The delivery or birth room should accommodate only one patient at a time, for two specific reasons: (1) It is more difficult to maintain a rigidly aseptic technique in a room in which more than one patient is being delivered. (2) With two or more patients in the same room there is greater danger of mixing babies.

Birth rooms should be on the order of regular operating rooms, having tile floors and tile walls unless some other hard finish is desirable. A pleasant shade of green is agreed to be most satisfactory for the eyes of the patient and the workers. While there should be the necessary instruments and supplies, the most important feature is a proper obstetrical table or bed for the actual delivery or labour. Such a bed or table must be adjustable, permitting ready movement of the patient to any position, raising of the foot and lowering of the head without difficulty or disturbance to the patient in case of shock or hæmorrhage. Specially designed obstetrical beds are available on the market; these provide such adjustments and embody features which are designed to assist the patient in her labour and provide the means for maintaining good technique.

While the birth room may contain the facilities for sterilization of basins, utensils, and instruments, it is preferable that this procedure be carried out in the service room. Every provision should be made for maintaining an aseptic technique comparable to that of the operating room. All persons permitted in the delivery or birth room should wear sterile gowns, caps, and masks covering the nose and mouth. Equipment for anæsthesia should be available.

Nurseries

As already stated, provision should be made in a separate nursery for all babies showing any signs of rash or infection. It is well to have the general nursery in a separate part of the obstetrical department where the noise can be cut off from the mothers. It is customary to have this unit as close to the labour and delivery suite

as possible, with a glass partition or window along the corridor so that friends can see in without entering the nursery. The nursery unit should consist of an anteroom, a preparation or bathing room and a linen closet, in addition to the nursery proper where the individual cribs are so distributed that each baby may have as close as possible to 500 cubic feet of air space.

It is preferable to have individual or separate cribs than to crowd several together on a frame or portable truck along the wall. Inasmuch as the nursery requires as much natural lighting and air as possible, it is best to place it in a corner of the building where windows can be available on two sides. The bathing or dressing room should be equipped with a heated table upon which the newborn can be placed when being dressed, and also have a bathing sink with drainboard, so that they can be bathed in sterile running water with automatic heater and thermostat control.

The dressing room should have ample facilities for cupboard space to provide for individual trays for each infant and possibly heated linen supply if not provided for elsewhere.

Adjunct Facilities

Clinical laboratory and x-ray facilities need no description here since they are usually provided as part of the general service of the hospital. There is no need of special facilities for this department. However, in the larger hospitals when occasion permits, there should be facilities on the birth room floor for urinary and blood examinations so that routine analyses as well as blood typing can be carried out.

Where space permits, the organization of a metabolic ward is worthy of consideration. Early and late toxæmias of pregnancy are admitted to this ward. One member of the staff is responsible for it, and a supervising nurse is permanently in charge. Facilities for doing blood chemistry are provided by the main hospital laboratory.

SECTION 3.—ORGANIZATION OF THE DEPARTMENT

The obstetrical department in every hospital should have *organized medical supervision.* This must be considered as the first necessity in the proper management and control of such a department. The hospital with a closed staff usually has this supervision already provided. It is in those hospitals open to all practitioners that the problem of providing within themselves any coordinated medical supervision is difficult.

In every hospital it should be regarded as essential that the obstetrical department should be a separate unit, wing or floor, entirely divorced from the rest of the hospital, especially as regards nursing and adjunct personnel. Unless this be obtained, it is almost futile to attempt any real supervision or control. Supervision of wards, nurseries and delivery rooms naturally comes under two main divisions, *viz.*, medical and nursing services.

MEDICAL STAFF

"Closed" Hospitals

The hospital with a "closed" organized staff usually has efficient medical supervision by attending and resident staffs. The head of such a department is usually a specialist in obstetrics who is responsible for the proper organization of that department, the relationships within the department and the coordination with other divisions of the hospital. He must lay down the policies of the department, establish and maintain a standard technique, and call regular departmental staff meetings for discussion of the obstetrical work. In addition, he is responsible for the formulation of a well organized program of education for those interns and medical students assigned to the obstetrical division.

Closed Hospitals with a "Courtesy" Staff

In this type of hospital where occasional practitioners or members of the "courtesy" staff may attend private cases, there is very little supervision over the care of the private patient attended by other than the members of the active staff. It should be recognized by all doctors using the hospital facilities that the care of such patients be subject to staff supervision in so far as such care affects the interests of other patients. This supervision should be effective and yet as inconspicuous as possible to avoid giving offence.

It would seem that, without giving undue power to the nursing supervisor, she must be the connecting link between the outside medical attendant and the head of the department. She must have definite instructions to report immediately to the head of the department any unusual or disturbing circumstances, appertaining either to the condition or the care of a patient, which, in any way, might prove detrimental to the interests of other patients. The fact that a patient is showing evidence of puerperal infection, for example, is information which should be immediately available to the head of the department who would then see that steps be taken at once to isolate the patient. All too often such information is available only after other patients have been exposed and further dissemination has occurred.

All medical and nursing personnel should clearly realize that, in an obstetrical department, "bad news" cannot remain unknown and any evidence of infection during the puerperium occupies first place in the category of "bad news". Prompt recognition and isolation of such cases is vital to the interest of patients and doctors. One can only commiserate and not condemn the doctor unfortunate enough to have such occasional case develop in his care and the general attitude should be rather to condemn him who attempts to cover up such a circumstance. Repetition of such camouflage should result in refusal to allow such a practitioner the privileges of the department. Repeated bad obstetrical results on the part of any one practitioner would make necessary the tactful questioning and, perhaps, intervention of the head of the department, in the hope that help might be given and repetition prevented.

Hospitals with "Open" Staff

Hospitals with an "open" staff and those which rarely have obstetrical specialists on their staff, have the greatest difficulty in perfecting the organization of the obstetrical department.

If such hospitals have no organized medical supervision, the Board of Management should request a meeting of all doctors using the obstetrical wards for the purpose of electing a small supervisory obstetrical committee of, say, three members to serve for a period of one or two years. The group would appoint one of this committee to act as chairman; he would function as head of obstetrics and to him difficulties arising in this division of the hospital would be referred for settlement, either by himself or the committee as would be deemed necessary. With this organization provided, there would then be continuous cooperation obtained between the nursing supervisor and the medical staff through the chairman of this committee. At the end of the prescribed term of duty, this committee, or a new committee of other practitioners willing to serve, could be elected and, in this way, responsibility would be maintained and could be assumed by various members of the staff. This committee of the medical staff and also the nursing staff should clearly understand the great necessity of being constantly on guard against outbreaks of puerperal infection in the hospital and the prime importance of immediate isolation. Some such organization of the practitioners in the open hospital, as outlined above, is imperative if the common interest is to be served.

Nursing Personnel

The entire department should be under the competent supervision of a trained, graduate, registered nurse. This presupposes a person of good executive ability and administrative experience who has had an opportunity to further prepare herself in the management and technical procedures concerned with such a department. In other words, this person should have had special training and post-graduate experience of at least six months in an outstanding maternity hospital or in an obstetrical department of a well organized general hospital. Such a supervisor must possess a thorough knowledge of maternity work and obstetric practice; she must have the usual qualifications of an executive officer, that is, good

supervisory, executive, and teaching ability, tact, diplomacy, sympathetic understanding of human nature, and other special qualifications required particularly in this work.

It is quite obvious that in most obstetrical departments more than one graduate nurse is necessary for supervisory purposes. If the size of the department warrants, it may be necessary to have a graduate nurse in charge of the three units mentioned to share the responsibility of supervision in the various assignments.

Of vast importance is the type of nursing service in this department. If done by graduate nurses, only qualified registered nurses should be engaged, and a ratio of at least one graduate nurse to every four or five patients by day and eight to ten patients at night should be a minimum for post partum care, provided adjunct nursing services such as maids or attendants are available for doing the supplementary or non-technical work.*

In the nursery the peak load comes during the morning hours when there should be one nurse for every six babies. The ratio may be reduced during the afternoon and at night to one nurse for every twelve babies. There should always be a graduate nurse in charge. The proportion of students to graduates can better be determined according to the requirements of the specific case, such as size of the nursery, type of cases, conveniences, etc. It should be worked out on this basis.

In the delivery room suite for the observation and care of the patient a much larger ratio of nurses is expected. In addition to the supervisor of the department there should be available at least two nurses for the care of each case When student nurses are used only those who have had their operating room training should be permitted to work in the department, but additional student nurses may be present in the labour room for observation purposes in connection with their training.

Student nurses require adequate training in theoretical and practical obstetrics. A period of four months training in the department is considered minimal. During their tour of service in the obstetrical division they must obtain regular experience in the various units so as to cover the services in predelivery, delivery, ward, and nursery. Organized, supervised demonstrations and practical instruction are necessary; for this reason the supervisor of the department and her assistants must be good teachers. A comprehensive course of lectures is required as part of the education of the student nurses in this field.

The assignment of duties in the department with hours on duty and off duty can be made only by the supervisor and her assistants. But such schedules of duties as developed should provide sufficient personnel for adequate coverage of the service at all times during the day and night.

Assuming that there is the proper supervision, the allotment of student nurses should be at least one-third greater than graduate nurses. In other words, for day duty a ratio of one to every three or four patients, and for night one for every five or six patients should be minimum for post partum care.

Adjunct Personnel

Adjunct personnel in the department would consist of the following: ward maids or attendants for doing non-technical tasks in the wards; nursery maids for the nursery; and a cleaner for the operating rooms. These should be provided in proportion to the amount of work of non-technical nature which can be entrusted to such a group.

No member of the personnel having a cold, sore throat, or infection may be permitted to remain on duty. Occasional nose and throat cultures of the personnel are of value in disclosing sources of infection.

Section 4.—Clinical Records

The clinical records in the obstetrical department are of no less importance than in connection with other cases, and in no institution should they be neglected. In every instance the attending physician should be responsible for a complete record of the mother and the newborn. The following data should be included in the maternal record:—

Contents of the Obstetrical Record

The obstetrical record falls into three parts: (*a*) Prenatal or history of pregnancy; (*b*) labour; (*c*) post-partum and puerperium, consisting of the following component parts:

1. Identification and registration data, which include name of parents with maiden name and parentage of both, address, age, nationality, religion, occupation, or other identification or registration data required.

2. *Past history.*—(*a*) General health with special reference to such diseases as scarlet fever, measles, diphtheria, rheumatism, goitre, nephritis, cardiac diseases, tuberculosis, anæmia, venereal diseases, and mental or nervous conditions. (*b*) Menstrual and marital history with special reference to frequency, duration and character of menstrual functions and history of previous pregnancies, miscarriages, labour, or puerperiums.

3. *History of present condition* with special reference to time and character of last menstrual period and abnormal symptoms, such as frequency of micturition, morning vomiting, nervousness, fetal movements, etc., as will establish a diagnosis.

Particular inquiry should always be made as to vomiting, headache, œdema, epigastric pains or disturbance of vision especially after the first three months.

4. *Physical examination.*—(*a*) General—appearance, nutrition, and muscular development; eyes, nose, throat, skin, breasts, and superficial parts of the body for pus, varicose veins, or other abnormalities; skeletal or locomotor system for bone abnormalities; heart, lungs, and blood pressure. (*b*) Special—external examination to determine duration of pregnancy, position of child, pelvic measurements (spines, crests, trochanters, external conjugate, and bi-ischial), condition of abdominal muscles, fetal heart (location, frequency, and quality); internal examination; condition of soft parts, abnormal discharge, relation of presenting part to brim of pelvis, and internal measurement or internal conjugate.

5. *Laboratory* or other special examination as x-ray, electrocardiograph, etc.; consultations.

6. *Provisional diagnosis* indicating term of pregnancy and position of child.

7. *Labour.*—Description of each of the three stages of labour:—

First stage.—Kind and frequency of pains; record of all internal examinations with findings; fetal heart; general condition of patient; time.

Second stage.—Detailed description of mechanism of delivery including note on condition of patient; hæmorrhage or other complications; time.

Third stage.—Detailed description of delivery or presentation with reference to hæmorrhage, complications, general condition of patient, bleeding, or other conditions; length of time. (If operative there should always be recorded indications for operative measures with full description of technique as in any other operative case.)

8. *Pathological report* including a gross description of placenta, and microscopic examination when necessary.

9. *Final diagnosis.*

10. *Puerperium or post-partum progress* with daily reference for ten to fourteen days or longer relative to general condition, complications, examinations, breasts, fundus, lochia, and all other conditions of progress of patients.

11. *Condition on discharge* as revealed through complete examination, particularly internal, to determine exact condition of genital organs.

12. *Follow-up* covering a period of at least six to nine weeks following labour, with re-examination at the expiration of twelve months after delivery.

There are various types of standard forms available for use in obstetrical cases. It is recommended, however, that blank forms be used following a definite outline as suggested in the record content. This will permit greater

*All nursing ratios are dependent to some extent upon the physical layout of the department and the nursing facilities provided.

facility in recording a complete history and reporting examinations rather than having the data limited because of space assigned in the stereotyped forms.

SECTION 5.—CONFERENCES

The work of the obstetrical department should be regularly and systematically reviewed by the obstetrical staff, with special reference to morbidities and mortalities. This can only be done when complete records of all patients are available. It is recommended that such a staff conference be held bi-monthly or monthly, for review and analysis of the activities of the department, special consideration being given to all work not up to the required standard. Once a year a comprehensive report of the year's work should be presented, when comparisons with such previous reports and, where available, reports from other hospitals can be made.

It is further recommended that conferences be held by the staff with the supervisor of the nursing department and officers of the hospital, in order to improve administrative and technical procedures, and also with representatives of the medical, surgical, or special services of the hospital, at which time points concerning co-operation between these departments and the obstetrical service can be fully discussed.

SECTION 6.—PROCEDURES

Important as are the physical facilities and the personnel, the preparation and carrying out of standard procedures in the obstetrical department should receive primary consideration, thus assuring the safest and most efficient care of each patient. It is recommended that such procedures be duly recorded as a guide in a manual of operation, to be revised from time to time as newer methods are introduced. A copy of such manual should be available at all times on the wards of the department, a copy put in the hands of each member of the staff and a copy presented to each new resident physician or intern as he comes to the service in order that he may study the same and thoroughly acquaint himself with its contents.

Following are described some of the more important suggested procedures.

PRENATAL CARE

Prenatal care consists of supervision, care, and instruction for expectant mothers. If maternal mortality is to be reduced every prospective mother must have adequate prenatal care, under the supervision of a competent physician, for it has been proved that many cases of maternal mortality and a great deal of maternal morbidity could have been avoided had pregnant women assured themselves of proper prenatal care.

The expectant mother should consult a physician as soon as pregnancy is suspected. The careful physician will take an adequate history, noting particularly previous illness or disease, miscarriages and nature of previous labours. A complete general physical examination should be made at first or second visit and, where indicated, if unable to afford private care, the patient should be referred to special clinics for reports or treatment. This examination should not overlook any of the systems and any evidence of acute or chronic disease, past or present. Wassermann blood test should be required and bacteriological examination made of any suspicious vaginal discharge. The examination will not be complete without recording the height and weight of the patient—excessive gain in weight indicating that special attention be given to the matter of dietetics, to the possible retention of body fluids or to disturbed endocrine function.

Special examination will be directed toward the breasts, abdomen and external genitals. At least three external pelvic measurements should be made: (1) the interspinous; (2) the intercristal; (3) the external conjugate and one internal measurement, the diagonal conjugate. At least one vaginal examination should be made from which any abnormalities in bony or soft tissues will be noted. Attention will be specially directed to the coccyx, the ischial spines, the pubic arch and distance between the ischial tuberosities.

If any definite foci of infection in teeth, tonsils or elsewhere have been found, these should receive immediate attention.

Suitable treatment should be instituted for any abnormal condition found when such is amenable to treatment. Anæmia may be mentioned as one condition very commonly present during pregnancy which responds in a measure to suitable treatment in a large percentage of cases. Supplementing the diet with an adequate amount of vitamin D and ensuring that the diet contains a sufficient amount of phosphorus and calcium in the natural form is important. In the matter of such things as clothing, diet, regulation of the bowels, bathing, care of breasts, rest, and exercise, sexual intercourse, etc., the patient should receive definite instruction.

Return visits should be made to the physician once a month for the first six months, and thereafter every two weeks—more often if requested by the doctor, or if the patient herself has anything special to report. At each visit a routine urinalysis should be made, the patient's weight recorded, the blood pressure taken, and recorded, and a careful watch kept for such early signs of toxæmia as too rapid increase in weight, œdema, headache, visual disturbances, rising blood pressure, nausea, vomiting, or abdominal pain. The patient will be required to report any departure from normal health and especially pain in the abdomen or bleeding from the vagina. The importance of early recognition and treatment of toxæmia, accidental hæmorrhage or placenta prævia cannot be too strongly emphasized.

When a prospective mother who has been attending a hospital prenatal clinic fails to report on her regular day, especially if some special home treatment has been instituted, some form of follow-up system by way of a visit from a district health nurse, should be employed if possible.* Co-operation from public health nursing services and maternity associations in this respect can usually be obtained in the larger cities. The importance of a carefully integrated medical social plan developed to serve as a contact between the clinic and the patient cannot be overestimated.

When a patient attends a hospital prenatal clinic but expects to be confined at home by a private physician, this physician should be notified promptly that his patient is in attendance at the clinic, and any abnormality reported to him. Without doubt definitely abnormal cases should be confined in hospital, where assistance from the specially trained obstetrical staff is readily available. If the patient expects to be confined at home, she should receive, at the clinic, specific instructions as to preparations necessary for labour.

The Prenatal Clinic

Prenatal care is a preventive measure with which every prospective mother should be fully cognizant. In formulating a program for teaching the importance of prenatal care and in disseminating the information in non-technical and understandable form, the hospital and its staff can play an important rôle. The clinic should be made as attractive as possible, even to the serving, when possible, of a cup of tea—a sort of social centre for those attending on that day—where problems may be talked over with the health nurse, patterns for baby clothes obtained, instructions given in the hygiene of pregnancy and infancy, and symptoms of the onset of labour and of threatened abortion, explained. Informative pamphlets for prospective mothers are published by the Dominion and Provincial Health Departments and will be furnished gladly to the hospital clinics for distribution.

Sometimes prenatal clinics are run under the auspices of lay or health organizations, interested in maternal and

*Reference here is to the excellent arrangement found in some of the larger centres. However, some larger hospitals have good ante- and post-natal clinics but no social service organization. Sometimes there is but limited, or no, public health nursing service. Such a situation requires some modification of these ante-natal arrangements. Unless the hospital is in a centre sufficiently small that every prospective patient, whether paying or otherwise, can anticipate ante-natal care by a personal physician there should be an ante-natal clinic.

infant welfare, but not associated with the hospital. Regardless of control, all clinics should be affiliated with approved hospitals and provided with organized medical and nursing services.

The prenatal records of the outpatient department should be correlated with the records of the inpatient department of the hospital, and the closest coordination exist between the medical staffs of the two divisions, in order that each physician may follow his own cases in the hospital as far as possible. Furthermore the prenatal record should be available at any time, day or night, when the patient is admitted to hospital.

ADMISSION

Obstetrical admissions are conducted similarly to other admissions, except that more privacy is required, and at no time shall the patient be delayed in the admitting office if suffering from labour pains.

On admission the prenatal history shall be attached to the patient's chart, and the attending physician or intern in charge of the case notified.

Care should be exercised that a patient obviously ill on admission, be not put to bed in a room with other patients, or that a patient be admitted from a home where there is communicable disease. There must always be available beds reserved for the isolation of patients known to be or suspected of carrying infection of any kind. On admission the patient will receive a bath, be shaved and given clean linen before being put to bed. The usual admission specimen of urine will be taken for submission to the laboratory, but, as this may be readily contaminated, if there be symptoms of toxæmia, a catheter specimen shall be taken and sent for an immediate report from the laboratory.

PREPARATION FOR LABOUR

The patient having been admitted, bathed, shaved, and given clean linen, is put to bed and then given an enema before being sent to the predelivery room. The vulva should always be covered by a sterile pad. Here she will be re-checked for the presence of any suspicious infection or sign of illness, and made as comfortable as possible in body and mind.

PREDELIVERY

Once definitely in labour, it is well to remove the patient to the predelivery room adjacent to the delivery or labour room, where she can be properly watched by the nurse in charge, during the first stage of labour. If student nurses are assigned to this duty, a qualified graduate nurse should exercise supervision, and she should check not only the condition of the patient, frequency and character of pains, etc., but also, at frequent intervals, the fetal heart sounds, keeping a record of her findings. Anything unusual or showing marked change shall be reported to the attending physician or intern in charge of the case. During the patient's stay in this room, careful aseptic care must be maintained.

If possible a diagnosis or probable diagnosis as to presentation and position of the fetus will be made from external palpation and auscultation of the fetal heart sounds. If labour has not been unduly prolonged, the pains are strong and evidence of progress is noted, it may be unnecessary to make a vaginal examination. For routine purposes rectal examinations are recommended. If one or more vaginal examinations are made, they must be made under the most careful antiseptic and aseptic technique possible, and the fact recognized that the fewer the examinations made, the better the patient's chances of not having infection introduced into the genital tract. Rectal examinations should suffice for noting the progress of labour, but where examination is desirable to obtain more definite information, one or two vaginal examinations carried out in the manner referred to, should carry a minimum of risk to the patient. It is important that a patient in the first stage of labour be given small quantities of fluid frequently, and, if labour is prolonged, enemata be repeated every eight hours. The patient should void at least every four hours, or, if unable to do so, such fact reported to the attending physician. Face masks must be worn at all times by physicians or nurses in attendance in the predelivery room.

DELIVERY

When the first stage of labour is over and the second stage well advanced, the patient is moved to the delivery or labour room, and here attended by physicians and nurses. There should be at least one scrubbed and one unscrubbed nurse on duty. The attending physician or physicians and scrubbed nurses, are gowned, capped, masked and gloved. The anæsthetist, unscrubbed nurse or other attendants, will wear gowns, cap, and a mask that covers nose and mouth.

The procedure of delivery must follow the most rigidly aseptic technique, comparable only to that of an abdominal operation. Hypodermic medication, intravenous outfits and solutions, and all other supplies needed in emergency situations of shock and hæmorrhage, must be in readiness close at hand.

Immediate Post-Partum

When the patient has been delivered, any necessary repairs are made, and, if there be no resulting shock or hæmorrhage, she may be returned to her ward or room. It is a good plan to make her warm and comfortable and let her rest in the labour room for the first hour after delivery. In this way, she can be more closely observed and the danger of shock and hæmorrhage obviated. Should they occur, it is much easier to cope with them in the labour room than in the ward or bedroom.

The nurse must keep the closest watch over the patient for at least the first hour following delivery. The fundus should be held throughout this period, or at least at frequent intervals, and gently massaged if not firmly contracted. If some form of ergot or pituitrin has not been used on the completion of the third stage, one or other or both should be administered on evidence of a poorly contracting uterus with more than very moderate bleeding.

It is most important to keep the patient very quiet during this time and not to allow her to nurse her baby for at least six to eight hours. Only one or two nearest of kin should be permitted to visit her during the first twenty-four hours.

The patient should receive ordinary or special nursing care, according to medication. Strict aseptic technique must be followed in changing vulvar pads, the nurse wearing a face mask.

The chief dangers to the mother during the first twenty-four hours are shock and hæmorrhage. Shock will be met with the usual measures of enforced quiet, extra warmth, and intravenous and hypodermic medication. Hæmorrhage will be frequently found to be caused by the formation of intra-uterine clot which should be expressed, and medication previously referred to, used. If it has been severe intravenous saline or blood transfusion, or both, may be required.

Puerperium

The puerperium is the period of six to nine weeks following labour during which time the patient should return to normal life and the uterus become fully involuted.

While the patient remains in hospital aseptic technique should be carried out in doing vulvar irrigations, changing vulvar pads, removing sutures, or in making examinations where there might be a possibility of introducing infection.

The nurse should observe and carefully record the usual data appertaining to the progress of the case, but will especially observe and record (*a*) condition of breasts and nipples; (*b*) consistency and size of uterus; (*c*) amount, colour and odour of the lochia; (*d*) any urinary disturbance; (*e*) pain or tenderness in abdomen or limbs; (*f*) chills and headache. During this hospital lying-in period, the physician visits the patient daily and records his own findings as to the patient's progress. Any treatments other than set forth in the hospital manual as routine, will be ordered by the physician in charge. During the latter part of her stay in hospital, she is encouraged to spend parts of each day lying forward as nearly as possible

on the abdomen, allowing the heavy uterus to lie forward, thus trying to prevent a retroversion.

A patient whose case is progressing normally will be allowed to sit up in bed on the fourth day unless there has been extensive perineal repair. She will be permitted to sit out of bed the ninth or tenth day and allowed to move about a little, providing she has a normal temperature. On the second or third day up, if everything appears normal she is allowed home. Before being allowed home, it would be very helpful to the mother, were she given a demonstration of the proper methods for bathing the infant and attending to its toilet.

DISCHARGE

Before discharge, and preferably just before being allowed out of bed, a careful check-up should be made of the patient's physical condition, and more particularly to the pelvic region; these findings should be recorded. An examination will be made to ascertain the condition of the perineum, vaginal walls, cervix, and the size and position of the uterus. There should be evidence of the satisfactory healing of the wounds and of proper involution before discharge be permitted.

A résumé of the confinement and puerperium will be recorded on the outpatient history form for reference when she returns to the clinic (if there be one) for post-natal examination. This is important, and will draw special attention to those cases where there has been prolonged or difficult labour, in order that previous pelvic measurements, etc., may be re-checked.

Before discharge, each patient should be given individual instructions with reference to diet, rest, remedial exercises and so forth. The patient having been instructed concerning how she should carry on when she goes home, the case records are completed and the usual discharge procedure is carried out.

FOLLOW-UP

The patient is instructed to return, when the baby is six weeks old to her physician or to the post-natal clinic, on which occasion a careful pelvic examination will be made, any displacement corrected and a suitable pessary fitted; suitable treatment will be given also for any cervical erosion or catarrh that may be present. Should further observation or treatment be required, she should return again on a given date, and thereafter as frequently as considered necessary by the physician. If the patient's general health be such that she requires special investigation or treatment directed especially to a certain system, it should be possible to arrange for this through some of the other hospital clinics. Careful records should be kept of the patient's condition at each visit to the hospital.

MORBIDITY

There are various indices of morbidity recognized in different hospitals in different parts of the world. Perhaps as useful a definition of morbidity as any is the one adopted by the British Medical Association. This Association recognized as morbid, a temperature of 100.2 on any two successive days during the first ten days post-partum, the temperature readings being taken bi-daily by mouth, the first twenty-four hours only being excepted.

By means of a definite standard by which the morbidity index is arrived at, it may be possible to detect faulty technique, and information furnished as to conditions leading to infection. Such a standard, as adopted by the British Medical Association, provides an excellent index of the efficiency of both medical and nursing services, and prompt measures taken to remedy any unfavourable conditions will doubtless save many lives.

ANÆSTHESIA

The administration of anæsthesia in obstetrical work is of two types: analgesia and surgical anæsthesia. Analgesia is generally used in cases of normal labour and may be administered by the nurse, the intern, or the assisting physician. Surgical anæsthesia is necessary in all cases of operative obstetrics such as forcep deliveries, version and extraction, Cæsarean section, etc. In such cases the anæsthetic should be administered only by a competent anæsthetist.

While chloroform and ether as anæsthetics are rapidly passing into disuse, nitrous oxide and oxygen are being used more universally. With the perfection of equipment the administration of both analgesia and anæsthesia is readily and safely controlled. The patient should not be allowed to use the anæsthetic herself; a nurse or intern should give her occasional whiffs during labour to minimize the pain but not to interfere with the full effect of the contraction of the uterus.

Newer anæsthetics and improved methods of administration, both local and general, are constantly making their appearance. An appraisal of these anæsthetics and methods of administration should be made by the obstetrician and the skilled anæsthetist before their introduction or adoption.

SECTION 7.—THE CARE OF THE NEWBORN

Immediately upon the delivery of the newborn, it should be held head down until the mucus has been removed from the throat. Care is to be taken to prevent contamination from the fluid which has accumulated below the maternal perineum by not letting the child lie in the septic area between the mother's thighs; it should be removed to a sterile towel. The mucus should be removed by a mucus tube before the child has a chance to inhale it. If there is any delay in the establishment of respiration, methods of resuscitation should be employed keeping in mind the following principles:—

1. The airway should be clear of obstruction from mucus.
2. When the asphyxia is of the pallid type, the child should be kept warm by immersion in a bath at 110° and gentleness substituted for too vigorous manipulation.

In instances of extreme gravity, in addition to methods of artificial respiration, the use of 5 per cent CO_2 in oxygen is desirable. Occasionally insufflation by means of tracheal intubation is a life saving measure. For this is needed a laryngoscope, a soft rubber (French No. 14) catheter and stylet for intubation and a soft rubber bag for holding the gases. Where this equipment is not available, mouth to mouth insufflation with gauze protection should be substituted.

The aseptic technique should be maintained for the cutting and treatment of the cord. An alcohol dressing should not be opened until the cord separates unless there is evidence of hæmorrhage or infection.

After the child has been identified and the prophylactic treatment for ophthalmia (1 per cent Silver Nitrate or 40 per cent Argyrol) given, it should be taken to the nursery, oiled, bathed and dressed. A careful record of the newborn should be begun at birth including sex, weight, measurements, colour, breathing, umbilical cord, birth marks, deformities, etc.

Nursery supervision of the newborn should be constant for the first few hours after birth.

The daily record should be kept of the infant's general condition, weight, cord, eyes, skin, and digestion. All abnormalities should be reported promptly.

Identification of the Newborn

This is a hospital problem of paramount importance. The method of identification should be promptly applied before the child is removed from the labour room and should be foolproof. The following methods are generally employed:—

1. *Footprints.*—This should be done in all cases as the most permanent means of identification.
2. *Adhesive sticker with names.*—A small piece of good quality adhesive plaster with name written in indelible ink is placed on the right shoulder blade or around the wrist of the newborn.
3. *Name necklace.*—The name appears on a series of small beads. This method is usually preferred by the mother because of its visibility.
4. *Name tags.*—When the infant is dressed a small name tag is tied to one of the buttonholes in addition to the one placed on the crib.

Very great care should be taken always when there are two or more infants in the nursery bearing the same name. In such instances the identification should carry the full name of the mother or such other means as would

make differentiation unquestionable. As this danger of "mixing" babies in a real, though often unexpressed fear of mothers, the careful routine of the hospital in this respect should be brought to their attention.

Artificial Feedings

Provision for making artificial feedings for infants must be available in all hospitals caring for maternity cases. In hospitals having 25 beds or less for obstetrical patients, this service will usually be carried on by the dietary department without any special room being set aside. In the larger hospitals having 50 or more beds for obstetrical patients, a special room should be available for making up the infants' feedings; this should be situated as closely as possible to the dietary department, inasmuch as the work can best be supervised by the dietitian.

The size of the room varies with the size of the service. The following equipment is usually required: work table, preferably with metal top which can easily be kept clean; refrigerator for keeping bulk milk and storing feedings when made up; utensil sterilizer for pans, containers, basins, etc.; bottle washer and sterilizer for cleaning and sterilizing bottles; cupboards of ample size for supplies; desk and rack for the necessary records and charts.

The entire room should be similar to an operating room in structure; that is, it should have a floor of tile, terrazzo, cement, or other material which can be flushed down to a drain. Tile walls should be built up to eight feet, but tile all the way to the ceiling is preferred. If such walls are not possible, a hard finish paint which can be washed is desirable.

Technique comparable to the operating room is essential. The milk supply should be obtained from approved sources. It may be necessary to pasteurize the milk; some hospitals do this themselves, but, because of the added expense of a small pasteurizing plant, milk is usually purchased already pasteurized.

SECTION 8.—EXTRA-MURAL SERVICE

The hospital can increase its service to the community in the following ways:—

1. The provision of ante-natal care and advice in its outpatient clinics not only to those planning hospitalization but also to those who, not being able to afford a private physician for the whole period, are yet able to employ his services for the confinement at home. Co-operation can be arranged between the private physician and the hospital clinic; in the case of indigents or those on relief, normal cases who prefer home confinement may secure the services of a private attendant under a suitable municipal plan in certain provinces or municipalities.
2. The provision in emergency of
   (*a*) A kit for intravenous transfusion of saline and glucose.
   (*b*) A kit for blood transfusion; and, at the same time, make available a list of donors.
   (*c*) An oxygen tent.
   (*d*) Portable tank of 5 per cent CO_2 in oxygen.

These services would be frequently life saving and could be self-sustaining by charging those who could pay or, in the case of indigents, be re-imbursement from the municipality.

H. B. VANWYCK,
Chairman, Larger Hospital Sub-Committee.

PART II.—OBSTETRICAL PRACTICE IN SMALL HOSPITALS

The obstetrical technique outlined in the preceding chapters may be accepted as the standard obstetrical technique in maternity hospitals or services in Canada and the United States. Obviously, many of the excellent requirements set forth cannot be applied to the many small hospitals without some modification. The extent of this modification will depend to a large degree upon the size of the hospital and upon its available facilities. This particular chapter of this report is being prepared from the viewpoint of the practitioners working in the small hospitals with capacities ranging up to about twenty-five beds. These are almost all general hospitals, admitting patients both private and public, and with a wide variety of human ailments. While all kinds of patients are cared for, the maternity work usually ranks first in importance.

In our small hospitals, it is impossible to follow the more elaborate technique for several reasons. There is not the space, nor the equipment, nor the numerous staff, nor the necessary financial support. The small hospital must accommodate the common people of limited means. It must provide safety and efficiency, but by the most simple possible methods. Without deviating at all from loyalty to one great principle, the prevention of sepsis, the small hospital must work effectively by means within its reach.

Obstetrics is the most important department of work in any small hospital. It touches vitally the welfare of mother and baby, the family and the community, and the future generation. A hospital should be a friendly place, a restful place, a refuge where the expecting mother may retire when her time comes, where every necessary care and safeguard is assured. The staff, nursing and medical, must be technically efficient and, just as important, should be well endowed with judgment, sympathy, and patience. New lives are to be brought into the world and it is no mere figure of speech to say that every new life coming into the world is met by another on the very edge of the grave. The statistics of maternal mortality should make for seriousness. Obstetrics is a serious business and every hospital accepts an important responsibility when it admits and accepts cases of maternity; that responsibility is shared equally by all of the staff, medical and nursing.

SECTION 9.—ACCOMMODATION, EQUIPMENT AND FACILITIES

The *accommodation* in a small hospital should be ample and not crowded. Heating and ventilation, water supply and sewage disposal, are all of first importance. There should be space for isolating special patients. There should be accommodation for private and semi-private wards for patients who wish for privacy. The sterilizing equipment may be simple but it must be safe and adequate.

It is important that the patient be delivered in a room sufficiently apart or sound-insulated that she does not disturb other patients. There is a great difference among patients as to the amount of pain that is suffered and the degree of their power to endure such. It is no exaggeration to say that the noise from the lying-in room can be terrifying. The common practice in small hospitals of delivering patients in their rooms cannot be recommended.

The *delivery room* should be adequately, although not lavishly, furnished. A good obstetrical table, such as the MacEachern bed, is highly desirable, although much can be done with a simple operating table fitted with stirrups. There should be provided, also, an instrument table, anæsthetist's table and stool, obstetrician's stool, irrigator stand with basin and jar, basins and stands, bassinet and a reasonable stock of instruments, gowns, gloves, and supplies.*

The delivery room *lighting* should be adequate and should be flexible, but need not be expensive. The overhead light or lights may be of simple construction and should be so protected or diffused that the patient is not annoyed by glare. The whole room should be adequately illuminated. Of most importance is the spotlight for perineal work. A pedestal light, preferably with an emergency battery base, is particularly useful. A number of excellent models, at moderate price, are available, although an ordinary pedestal gooseneck light would suffice.†

There should be an *isolation ward* where infected patients may be kept separate from the others. In a small hospital, such a ward cannot be located in a separate building; nor would it be feasible, even though desirable, to have a separate delivery room for such patients, nor to have a separate staff for their care. The income of a

*See equipment lists for Small Hospitals, Bulletin No. 1, issued by the Canadian Hospital Council, 184 College Street, Toronto. A copy may be obtained upon request.

†See Report on Construction and Equipment, Bulletin No. 3, Canadian Hospital Council, Sub-Committee on Operating Room Lighting, Dr. A. T. Bazin, Chairman.

small hospital is too limited to provide for such extra services. Rather, in the face of unavoidable limitations, the staff must assume unusual care to prevent carrying infection from patient to patient. In a small hospital the same staff will at times have to care for a great variety of patients and, therefore, the exercise of the utmost care and good judgment is essential; such can be very efficient.

A sufficient *laboratory* is necessary. A complete urinalysis outfit and a blood counting apparatus are the most essential. There should be also facilities for matching blood, for blood transfusions, and for giving interstitial and intravenous treatments. Tubes should be available to send blood away for blood chemistry studies, should such not be done locally.

SECTION 10.—APPLICATION OF RECOGNIZED STANDARD OBSTETRICAL TECHNIQUE IN A SMALL HOSPITAL

No matter what modification in recognized standard obstetrical technique may be necessitated by the smallness of the hospital, its lack of facilities or the inadequacy of its staff, there are fundamental principles that can never be ignored in obstetrics. There is one fear that should be the constant companion of every doctor and every nurse—the fear of infection. Because of the high percentage of obstetrical deaths due to puerperal sepsis and because most of this sepsis is introduced from without, the greatest single problem, in both large and small institutions, and in the home confinement, is to avoid and prevent sepsis.

First Stage

When a maternity patient is admitted to a small hospital, in almost all instances, she will have selected her own doctor and will be his patient. She may have been under his care during her whole term, or, as often happens, the doctor may not see his patient until she be admitted, or until she be in labour. The doctor takes charge and that patient is his special responsibility. He must ascertain her condition and learn what is essential in her history. If she has borne other children the pelvic measurements will probably be all right, but should be checked, nevertheless. He will ascertain the fetal position. He will look for evidences of toxæmia or disease. A wise practitioner at this early stage will rarely make a vaginal examination; in that way danger lies. It is a safe rule to guard well the birth outlet, admitted to be the main inlet of infection. One with some experience can easily ascertain all that is necessary to know at the beginning without a vaginal examination. If labour has started he should order shaving of the perineum and vulva, and an enema. No further treatment need or should be given. After the enema has acted, a sterile pad should be placed over the vulva. It is helpful at this stage to give some sedative. There is a large range of these sedatives from which to make provision and selection. As the first stage advances and pains become stronger, Morphine 1/6 grain, with 1/150 gr. of Atropin, or Scopolamin, may be given. The patient then should be reassured and, as far as possible, left alone. Leave a bell within reach that a nurse may be summoned should it be necessary. During this time the rule should be "hands off". There is no need for the nurse to frequently disturb the patient by inspection of the vulva, and, by spreading the labia with fingers which are not surgically clean. Hands off! A nurse within call and with her ears open can attend other patients or perform other duties, all the time listening for sounds that are significant. (Should a soundproof room be provided, as recommended above, the nurse would be required to stay more closely with the patient.)

Second Stage

As the small hospital does not have interns and other doctors may not be in the building, it is important that the doctor be where he can be located when the second stage begins. If there be a phone available, he should enquire concerning progress from time to time. One nurse alone must suffice for ordinary cases. She will have instruments and sterile basins and dressings and antiseptic solutions all ready. If advisable, the doctor may direct the nurse to give whiffs of chloroform. Up to this stage there should have been absolutely no handling of any part of the genitals. The vulva is cleansed with scrupulous care and covered with sterile dressings, kept moist with an antiseptic. Masks should be obligatory for both the doctors and the nurses. (Any nurse or doctor with ozœna should not be engaged in obstetrical work.) One towel may be placed under the buttocks and another over the lower abdomen. The doctor may use one gloved hand for vaginal examination, and the other hand can be kept for general assistance. Thus the doctor can oversee the administration of the anæsthetic, and follow closely the course of labour. The nurse should do this and attend to the anæsthetic at the same time. Should the labour continue to be unduly slow, provided that the cervix is retracted over the baby's head, forceps may be gently applied.

During such a labour, it has been an actual advantage to have as few attendants, and as little handling of the birth outlet as possible. Thereby the possibility of infecting the patient has been reduced.

Third Stage

When the baby has been born, the maternal parts should be covered with a sterile pad, or a sterile towel, or both. The baby should be cared for till respiration has been established, then the cord can be tied and severed and the baby given to the nurse to take to the nursery. If there are other calls, the baby may be oiled, wrapped up and left for the time being. In the delivery room the patient remains under the care of the doctor, and, if all goes normally, he does not need the help of a nurse. He should be with his patient watching the amount of blood loss, the rate of the pulse and the tone of the uterus. It is advisable not to massage the uterus until the placenta has been passed. If left alone, usually there will form a retroplacental clot and, after fifteen minutes or more, the patient will proceed to expel the placenta. Here again patience and non-interference are indicated. The use of force to compel the explusion of the placenta is unwise and has an element of danger. Fragments may remain in the uterus and later are apt to cause trouble. Again let it be emphasized that gentleness and unlimited patience are all important.

Following the expulsion of the placenta, it is customary to have a nurse massage the uterus for at least an hour, and to keep the patient under constant observation. However, it is the plain duty of the doctor to be his own observer. The patient is his own personal responsibility, and that responsibility should be delegated to none other. After the doctor is satisfied that the condition of the patient is satisfactory, she should be returned to bed. He should then give the necessary orders, arranging that the patient, for a few hours, will be kept under observation but not unduly disturbed. If anything abnormal should occur, such should be reported at once to the doctor; he should be readily accessible.

Infant Care in the Small Hospital

The general routine recommended in Section 7 should be applied.

Puerperal Infection in the Small Hospital

Puerperal infection is the most serious problem in every hospital, large or small. In spite of every precaution, cases of sepsis do occur. Without doubt, some of these are caused by some infection already in the system, awaiting a suitable chance to flare into activity, but it is believed that very many cases arise from infection brought to the patient from without. Hence, it has been urged that there should be the least possible handling of the patient during labour. Whatever the source of the infection, the problem in every hospital is how best to treat these cases and prevent spread of the infection.

Immediate segregation of the patient has been urged in the preceding chapters as of first importance; emphasis has been laid, also, upon the necessity that nurses attending these cases have no nursing contact with other cases of any kind, or at least with any other maternity cases. This is an arrangement of the desirability of which there can be no argument. However, in small hospitals accom-

modation may be very limited and the staff may be quite inadequate. In the presence of an infection, a very difficult situation arises, a solution for which must often be found on short notice. Shall the hospital under these unfavourable conditions continue to accept new patients, or should all further maternity cases be excluded until the infection has been cleared up?

One must consider whether it is more dangerous to the patient to refuse her admission or to expose her to possible contact with infection present in the hospital. To some extent, the answer will depend upon the evaluation of these two factors. Unless there be most urgent necessity for the admission of a patient to a hospital wherein is a case of puerperal sepsis (or erysipelas or other streptococcal infection), it is advisable to close the hospital temporarily to all obstetrical cases. No patient should be admitted unless the infected patient can be separated.

However, if a patient must be admitted, the danger of cross infection can be reduced by unremitting care in every detail of technique. A much greater responsibility is placed upon everyone, but particularly upon the nursing staff, when clean and infected cases cannot be separated. Eternal vigilance is the price of safety.

Control and Supervision of Obstetrical Work

This is by no means as easy in the small hospital as in the large hospital. There is no separately organized obstetrical medical staff and, as all of the local doctors are doing general practice in all probability and therefore are more or less on an equal footing, it is difficult and embarrassing for one of the local group to assume supervisory responsibility for the obstetrical work in the hospital.

Nevertheless this does not imply that adequate safeguards cannot be set up. On the contrary, the medical staff as a whole cannot but realize that there is an added need for a workable set of *staff regulations* which will safeguard the patients and at the same time meet the special difficulties and problems inherent to the small hospital. These regulations need not be lengthy but should be of sufficient clarity and sanity that their rigid observance by all can be effected without rancour or reluctance.

Such regulations should be drawn up by the medical staff itself. If not organized, the local doctors can be summoned by the chairman of the Board of Trustees or by the superintendent and an acting chairman appointed.

These regulations should contain the following, among other provisions:—

(*a*) Basic requirements in procedure should be elaborated, such as the technique of preparation, the use of gloves, the wearing of masks, postpartum care, the care of the infant, etc.

(*b*) Requirements respecting consultation in the case of operative interference, therapeutic abortion, craniotomy, etc., should be set forth.

(*c*) Incipient or even suspected infection in mother or child should result in immediate isolation without awaiting the doctor's visit.

(*d*) Doctors from neighbouring towns or villages should be requested to name a local doctor who could be called in case of sudden emergency.

(*e*) The superintendent should be given sufficient authority to permit the due observance of these regulations.

SECTION 11.—THE SMALL HOSPITAL AND THE PHYSICIAN

There should be the heartiest good will and co-operation. The hospital can easily assist the doctor by keeping him supplied with sterile supplies and allowing him the services of an outside nurse, unless there should be an unusually busy time at the hospital. This service can be cheerfully rendered and paid for at the cost price.

The doctor can well reciprocate, and it should be his wish and pleasure to relieve the nurses as far as possible of the work that he himself can do. He should request the amount of attendance that is necessary but no more. Nurses' work is hard work. For instance, why should a busy nurse stand by and massage the uterus for an hour after the placenta has been passed? Why should a doctor pull off his gloves and pass out of the picture when he might remain and help? It is possible for some doctors to act the small tyrant, and to forget that there is no reason why a doctor should not also be a gentleman. He should be considerate of the members of the nursing staff and ease their load as far as possible.

R. G. SCOTT,
Chairman, Small Hospital Sub-Committee.

NOTE.—When printed in booklet form, this report will have added to it:—

1. A checklist of furnishings and equipment for the maternity department.
2. An outline of a model obstetrical routine with full details covering technique and procedures.
3. An addendum concerning visitors.

This report is in two parts:

1. The first section, which is signed by the Chairman.

This section of the report was approved.

2. The supplementary report dealing with "Obstetrical Procedures and Practice in Hospitals."

This section of the report was received and referred to the Canadian Hospital Council for consideration.

OFFICERS

The following are the officers of the Association for the ensuing year.

President—Dr. T. H. Leggett, Ottawa.
President-elect—Dr. K. A. MacKenzie, Halifax.
Chairman of General Council—Dr. Geo. S. Young, Toronto.
Honorary Treasurer and Managing Editor—Dr. F. S. Patch, Montreal.
General Secretary—Dr. T. C. Routley, Toronto.
Editor—Dr. A. G. Nicholls, Montreal.

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British Columbia—Dr. G. F. Strong, Vancouver.
Alberta—Dr. D. S. Macnab, Calgary.
Saskatchewan—Dr. J. E. Bloomer, Moose Jaw.
Manitoba—Dr. E. S. Moorhead, Winnipeg.
Ontario—Dr. Duncan Graham, Toronto;
Dr. J. C. Gillie, Fort William.
Dr. W. K. Colbeck, Welland.
Quebec—Dr. A. T. Bazin, Montreal;
Dr. Léon Gérin-Lajoie, Montreal;
Dr. J. C. Meakins, Montreal.
New Brunswick—Dr. A. E. Macauley, Saint John.
Nova Scotia—Dr. J. R. Corston, Halifax.
Prince Edward Island—Hon. Dr. W. J. P. MacMillan, Charlottetown.

CHAIRMEN OF COMMITTEES

Personal Archives—Dr. C. F. Wylde, Montreal.
Ceremony—Dr. J. S. McEachern, Calgary.
Constitution and By-Laws—Dr. R. I. Harris, Toronto.
Credentials and Ethics—Dr. Ross Mitchell, Winnipeg.
Economics—Dr. Wallace Wilson, Vancouver.
Medical Education—Dr. F. J. H. Campbell, London.
Group Hospitalization—Dr. F. W. Routley, Toronto.
Hospital Internships—Dr. J. J. Ower, Edmonton.

Hospitalization (Advisory Committee)—Dr. S. R. D. Hewitt, Saint John.
Maternal Welfare—Dr. J. D. McQueen, Winnipeg.
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Lectureships, Scholarships, Awards—Dr. J. C. Meakins, Montreal.
Osler Memorial—Dr. W. W. Francis, Montreal.
Pharmacy—Dr. V. E. Henderson, Toronto.
Cancer—Dr. J. S. McEachern, Calgary.
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Post-graduate Committee, and *Central Program Committee*—Dr. Duncan Graham, Toronto.
Study Committee on Nursing Education—Dr. G. Stewart Cameron, Peterborough.
Nutrition—Dr. F. F. Tisdall, Toronto.
Conference on Medical Services in Canada—Dr. A. T. Bazin, Montreal.
Public Health—Dr. F. W. Jackson, Winnipeg.

PLACE AND DATE OF NEXT ANNUAL MEETING

The next annual meeting of the Association will be held in Halifax, N.S., on June 20, 21, 22, 23, 24, 1938.

PASTEURIZATION OF MILK

The following resolution was approved by Council, with instructions that copies be sent to the Federal and Provincial Ministers of Health, and the Provincial Medical Associations:

"WHEREAS raw milk may be the means of transmitting various types of serious infectious diseases, such as bovine tuberculosis, typhoid fever, undulant fever, scarlet fever, diphtheria, septic sore throat, etc., and is a major factor in high infant mortality; and

WHEREAS it has come to our attention that there are many areas in Canada where raw milk is still distributed and sold:

BE IT RESOLVED THAT this Association go on record as endorsing the compulsory pasteurization of all milk offered for sale."

VENEREAL DISEASES

The following resolution was approved and passed to the Minister of Pensions and National Health:

"WHEREAS venereal diseases constitute a problem of major importance; and

WHEREAS Canada, for eleven years, had a most effective plan for the control of venereal disease involving Dominion and Provincial cooperation and organized education; and

WHEREAS, in 1932, the Division of Venereal Disease in the Dominion Government was dissolved and grants to the provinces for this purpose cancelled, also grants for educational purposes discontinued, only to be restored in part; and

WHEREAS three regional conferences held in 1931, as well as the Dominion Council of Health at a meeting held in December, 1931, all recommended that the scheme be extended and grants increased;

THEREFORE BE IT RESOLVED that the Dominion Government be memorialized and asked to re-establish the Division of Venereal Diseases in the Federal Department of Pensions and National Health; to reinstate the grants to the Provinces; and to make adequate provision for educational purposes throughout Canada to the end that the Canadian scheme be once more put on an effective basis.

MEETING WITH REPRESENTATIVES OF MEDICAL FACULTIES

Dr. W. D. Cutter, of the American Medical Association, came over to attend a conference of representatives of medical schools in Canada, to discuss the survey of Canadian Medical Schools which was made some time ago by the American Medical Association. This conference was attended by representatives of all medical schools in Canada except the University of Toronto, University of Montreal and Laval University. Dr. Cutter was anxious to get an expression of opinion of representatives of medical schools as to the policy they would like adopted for the future—that is, whether they wish the American Medical Association to continue the grading of medical schools in Canada, or whether they would prefer that the medical schools themselves or some other body they might set up should take over this task. Dr. Cutter expressed the opinion that, if this were the case the American Medical Association would be happy to withdraw and would give the Canadian body every support and cooperation. The following suggestions were made:

1. That the C.M.A. Committee on Medical Education should consider the advisability or otherwise of the C.M.A. or some other Canadian organization taking over the approval of Canadian medical schools.

2. That the C.M.A. Committee on Medical Education consider the possibility of developing in the C.M.A. a body somewhat similar to the Council on Medical Education and Hospitals of the American Medical Association.

3. That, if the C.M.A. Committee on Medical Education would advise the cooperation of the Canadian Medical Association in the grading of medical schools, or would suggest the taking over of this grading by a university committee under the C.M.A., then this Committee might make such preliminary report to the October meeting of this Executive, at which time arrangements could be made for a joint conference at the time of the American Medical Association conference on Education in Chicago.

This matter was referred to the Committee on Education for study and report.

RADIO BROADCASTING

Considerable discussion took place with regard to the broadcasting of quack remedies over the radio, and it was the unanimous opinion of those present that this is a matter which will require continuous effort and vigilance on the part of the authorities if the practice is to be curbed in the interests of the public.

CONCLUSION

In addition to the foregoing consideration was given to a great many other details in connection with the work of the Association, which were passed to the various committees for study and report.

All of which, on behalf of the General Council of the Canadian Medical Association, is respectfully submitted.

T. C. ROUTLEY, *General Secretary.*

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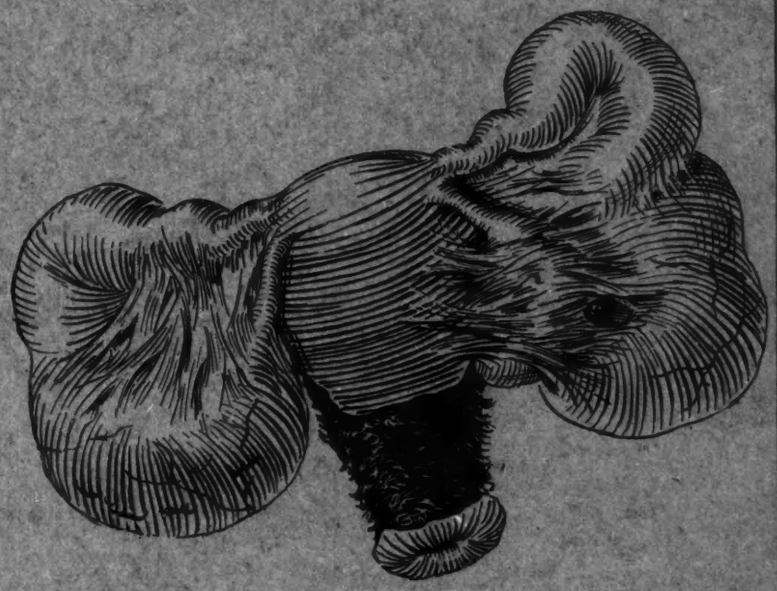
Prevent Pelvic Infection

ARGYROL



The prevention of pelvic infection lies in the early and successful treatment of the acute gonococcal inflammation.

The early use of Argyrol solution (10 per cent) in the urethra and cervical os has given most satisfactory results. The infected parts are still accessible and amenable to local treatment and a favorable result may be expected. Argyrol is not only an efficient gonococcide, but it soothes the inflamed parts and thus encourages healthy tissue reaction with a quick restoration to the normal. The tragic sequelae of pelvic infection are thus averted.

Argyrol is *not* just another "mild silver protein." It is the prototype of all such products and has never been successfully duplicated. Chemically and clinically it is entirely unique; none other contains silver in the same physical and chemical state, nor protein of a similar high quality and suitability.

Argyrol's pH and pAg are controlled for use on delicate membranes; its remarkable detergent and demulcent properties, its bactericidal yet soothing action have never been duplicated. This is not a matter of opinion but of fact, established by many years of world-wide medical experience. Insure your results, specify the prototype—BARNES.

Argyrol is made only by A. C. BARNES

★ A. C. BARNES COMPANY, LIMITED, STE. THERESE, QUE.

FOR 35 YEARS SOLE MAKERS OF ARGYROL AND OVOFERRIN

DIARRHEA

"the commonest ailment of infants in the summer months"

(HOLT AND McINTOSH: HOLT'S DISEASES OF INFANCY AND CHILDHOOD, 1933)

One of the outstanding features of DEXTRI-MALTOSE is its low fermentability and consequent preference in the management of infantile diarrhea.

In summer diarrhea, "The best food to use is boiled skimmed milk, acid skimmed milk, or dried protein milk. Carbohydrates are added in the form of dextri-maltose."—*G. Wiswell: Infant mortality and its prevention, Nova Scotia M. Bull., 15:504-509, Oct. 1936.*

—•—

Concerning the treatment of diarrhea, "If the weight remains stationary, it is an indication that loss of substance is occurring through the stools, mostly in the form of alkaline salts. To equalize this loss of substance, the diet must be increased, but in such a way as to avoid causing fermentation. This may be done by adding dextri-maltose and preparations of protein to the food, increasing the calories until the infant is taking 160 calories per kilo. of body weight."—*H. L. Ratnoff, Nutritional disturbances, Arch. Pediat., 41:771, Nov. 1924.*

—•—

"A very frequent cause of underfeeding results from the improper treatment of diarrhea . . . . One of the greatest advances made in the science of infant feeding was the development of protein milk by Professor Finkelstein and the use of buttermilk or lactic acid mixtures. The great advantage of being able to feed the infant with fermentative diarrhea a food containing 12 calories to the ounce, like protein milk, after only one day on a starvation diet, is apparent. In addition, the further advantage of being able to safely add a carbohydrate like Dextri-Maltose No. 1 or No. 2 to the protein milk within a few days, enables one to gradually bring the infant up to its basal needs in a short time. When protein milk was first used, carbohydrate additions were advised against with the result that many children on it went into a state of collapse. The suggestion of Dr. Alan Brown of Toronto, Canada, that Dextri-Maltose be added to protein milk, was of great value."—*G. J. Feldstein: Underfeeding of infants and children, Arch. Pediat., 50:297-306, May 1933.*

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Regarding the treatment of diarrhea, "In our experience, the most satisfactory carbohydrate for routine use is Mead's dextrimaltose No. 1."—*F. R. Taylor: "Summer Complaints," Southern Med. & Surg., pp. 555-559, Aug. 1927.*

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"Again, following the teaching of the originator of protein milk, the carbohydrate added should be the one that is most easily assimilated. Dextri-maltose is the carbohydrate of choice."—*R. A. Strong: The diarrheas of early life, Mississippi Doctor, 14:9-15, Sept. 1936.*

"If the stools are acid, green, and excoriating, a food high in protein and low in fat, and carbohydrate is indicated. Dried powdered protein milk is very ideal here—one to ten dilution. On the other hand, if the evacuations are brown, watery, and stinking with putrefactive odors, a proteolytic diarrhea, it will be of advantage to add a small amount of carbohydrate, a dextrimaltose preparation being very efficacious."—*A. G. Dow: Diarrheas in infants, Nebraska M. J., 20:22-24, Jan. 1935.*

SERIOUSNESS OF DIARRHEA

There is a widespread opinion that, thanks to improved sanitation, infantile diarrhea is no longer of serious aspect. But Holt and McIntosh declare that diarrhea "is still a problem of the foremost importance, producing a number of deaths each year. . . ." Because dehydration is so often an insidious development even in mild cases, prompt and effective treatment is vital. Little states (Canad. Med. A. J. 13: 803, 1923), "There are cases on record where death has taken place within 24 hours of the time of onset of the first symptoms."

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"After the preliminary short period of starvation, protein milk should be used. . . . . When the diarrhea has been sufficiently checked, dextrimaltose may be added and gradually increased until from 4 to 6 tablespoons are being used."—*W. L. Denney: Acute nutritional disturbances of infancy, Univ. West. Ontario M. J., 2:192-197, April 1933.*

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In diarrhea, "Carbohydrates, in the form of dextri-maltose, well cooked cereals or rice, usually can be handled without trouble."—*B. B. Jones: A discussion of some of the commoner types of infantile diarrhea, and the principles underlying the diets used in their treatment, Virginia M. Monthly, 55:411-415, Sept. 1928.*

In the treatment of dysentery, "As a useful supplement, Bessau's thick rice water with 1 to 5 per cent dextrimaltose may be used, or soy bean milk, which also may serve as main nourishment in the rare cases of hypersensitiveness to cow's milk."—*O. Willner: Dysentery, in The Practitioner's Library of Medicine & Surgery, D. Appleton-Century Co., Inc., New York, 1935, vol. 7, p. 371.*

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In cases of diarrhea, "For the first day or so no sugar should be added to the milk. If the bowel movements improve carbohydrates may be added. This should be the one that is most easily assimilated, so dextri-maltose is the carbohydrate of choice."—*W. H. McCaslan: Summer diarrheas in infants and young children, J. M. A. Alabama, 1:278-282, Jan. 1932.*

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"When there has been a tendency to looseness of the bowels, a form of sugar which ferments but slightly, such as dextrimaltose, may be employed."—*W. Sheldon: The artificial feeding of infants, Practitioner, 134: 415-428, April 1935.*

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". . . . I begin to add carbohydrates slowly, by replacing ¼ ounce Casec every two days with ¼ ounce of Dextri-Maltose, preferably Dextri-Maltose Number one. As a rule, this is tolerated. When one ounce of Dextri-Maltose is used, the Casec, of course, should be discontinued."—*J. W. Reed: The etiology and treatment of diarrhoeas of infancy, Virginia M. Monthly, 53:732-735, Feb. 1927.*

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In treating chronic diarrhea, "You do not need to starve such patients, but you select a diet of dried protein milk with the addition of dextrimaltose given in small three-hourly feeds, or soured milk, or an ordinary half-cream dried milk, or a whey mixture."—*R. Hutchison: Lectures on Diseases of Children, ed. 7, William Wood & Co., Baltimore, 1936, pp. 26, 65, 71-72, 76.*

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"The effect of a combination of dextrimaltose depends on the relative properties of the two components. If maltose is in excess, it tends to cause fermentation and loose stools, while dextrins are non-fermentable. In the preparations commonly used, Mead's Dextri-maltose Nos. 1 and 2, the maltose is only slightly in excess of the dextrins, and therefore they are advantageous if there is a tendency to excessive fermentation."—*W. J. Pearson and W. G. Wyllie: Recent Advances in Diseases of Children, P. Blakiston's Sons & Co., Phila., 1930, pp. 74, 116.*

Just as DEXTRI-MALTOSE is a *carbohydrate* modifier of choice, so is CASEC (calcium caseinate) an accepted *protein* modifier. Casec is of special value for (1) colic and loose green stools in breast-fed infants, (2) fermentative diarrhea in bottle-fed infants, (3) prematures, (4) marasmus, (5) celiac disease.

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